

S  
362.29  
M26sap  
1988? Community  
Connection (Firm)  
Student  
assistance program  
training

# COMMUNITY CONNECTION

STATE DOCUMENTS COLLECTION

FEB 13 1991

MONTANA STATE LIBRARY  
1515 E. 6th AVE.  
HELENA, MONTANA 59620

STUDENT  
ASSISTANCE  
PROGRAM  
TRAINING



PLEASE RETURN

**MONTANA STATE LIBRARY**

S 362.29 M26sap 1988? c.1

Student assistance program training.



3 0864 00069882 2

**COMMUNITY CONNECTION**  
**1245 PARK GARDEN ROAD**  
**GREAT FALLS, MT 59404**

For parents  
for student

452-6241  
453 7665

Dear Workshop Participant:

Community Connection welcomes you to this special training event. It is hoped that this will be an enjoyable and valuable learning experience for you both professionally and personally.

If you have any problems, questions, or concerns during the workshop please feel free to ask any of the staff for assistance.

As you can see from the following schedule that this workshop will involve both days and evenings. **All** sessions are mandatory. We realize that this requires a tremendous commitment from those attending. However, past experience strongly supports this format and time.

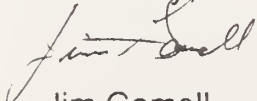
Here are the basic goals and objectives that we have used to guide us in the development of the workshop.

- 1. To expand and clarify our knowledge of alcoholism and chemical dependency.**
- 2. To be able to recognize and understand members of a chemically dependent and/or other dysfunctional family system.**
- 3. To gain a working knowledge of school programming and the day-to-day operation of a student assistance program.**
- 4. To expand our knowledge of available resources.**
- 5. To better understand our own feelings and defenses.**
- 6. To increase regard for the individuality of self, our young people and others.**


We are greatly indebted to the Montana Office of Public Instruction for their help in the printing of this manual.

We are very excited about this workshop and are glad that you have chosen to share this experience with us!

Sincerely,



Jim Gamell



Darlene Meddock



## **WELCOME**

One of the most pressing problems and concerns facing communities nationwide is the increasing use of chemicals by all age groups and all economic groups.

In no group is the problem of use and abuse more pressing than among our youth. In all groups across the nation the mortality rate has decreased in the last ten years with the exception of the 13-20 year old age group. Their mortality rate has increased and this increase can be directly related to the use of chemicals.

We welcome you to our workshop and hope that in the coming four days that the information we share with you will be of value and start us on a journey that we believe can significantly impact this serious problem.



## TABLE OF CONTENTS

	<b>Page</b>
<b>Use, Abuse and Dependency</b>	<b>3</b>
The Feeling Chart	11
Progression and Recovery of the Alcoholic	17
Behavior Signs	19
 <b>Feelings and Defenses</b>	 <b>22</b>
Johari Window	23
Confrontation	24
Leveling	29
"Courage to be Imperfect"	31
Defenses	42
Feelings	43
 <b>Family Aspects &amp; Children of Alcoholics</b>	 <b>45</b>
Family Illness Process	48
Family Structures	52
Family Illness in Children	61
Progression & Recovery of the Family	62
 <b>Enabling and Intervention</b>	 <b>67</b>
Family Enabling	70
Intervention	72
Intervention Data	79
Intervention: School Approach	88
Questionnaires	93
 <b>Treatment and Recovery</b>	 <b>101</b>
This is AA	103
Twelve Steps of AA	106
 <b>School and Community Programs</b>	 <b>107</b>
The Great Falls Experience	107
Great Falls Community Core Team Inc.	112
Great Falls Public Schools Student Code	114
Concerned Persons Group	119
Insight Class Format	125
 <b>Student Support Groups</b>	 <b>131</b>
Theory and Goals of Group	136
Observer Checklist	138
Defense Mechanism in Groups	141
Effective Feedback	143
Body Language	144
Leveling	148
Confrontation	150
 <b>Misc.</b>	 <b>152</b>



Digitized by the Internet Archive  
in 2013

<http://archive.org/details/studentassistanc27comm>

# STUDENT ASSISTANCE PROGRAM TRAINING

## DAY I

### Morning

7:30 - 8:00	Registration
8:00 - 8:10	Welcome and Orientation
8:10 - 9:45	Use, Abuse and Dependency
9:45 - 10:00	Break
10:00 - 11:15	Feelings and Defenses
11:15 - 12:00	Children of Alcoholics

12:00 - 1:00	Lunch
--------------	-------

### Afternoon

1:00 - 2:30	Family Aspects of the Disease
2:30 - 2:45	Break
2:45 - 4:00	Family and Professional Enabling
4:00 - 4:30	Intervention

4:30 - 6:00	Dinner
-------------	--------

### Evening

6:00 - 7:15	Treatment and Recovery
7:15 - 7:30	Break
7:30 - 8:45	"Those Who Know" Panel
8:45 - 9:30	Discussion and Review

## DAY II

### Morning

7:45 - 8:00	Coffee
8:00 - 10:00	School Program Specifics
10:00- 10:15	Break
10:15- 11:15	School Program Specifics (Cont.)
11:15- 12:00	Community Involvement

12:00- 1:00	Lunch
-------------	-------



Afternoon

1:00 - 2:00	Review & Discussion of Program Structure
2:00 - 2:30	Introduction to Support Group Lab.
2:30 - 2:45	Break
2:45 - 4:30	Support Group Lab.
4:30 - 6:00	Dinner

Evening

6:00 - 9:30	Support Group Lab.
-------------	--------------------

**DAY III**

Morning

7:45 - 8:00	Coffee
8:00 - 12:00	Support Group Lab.
12:00- 1:00	Lunch

Afternoon

1:00 - 4:30	Support Group Lab.
4:30 - 6:30	Dinner

Evening

6:00 - 8:00	Group Closure
8:00 - 9:30	Discussion of Support Group and Group Facilitating

**DAY IV**

Morning

7:45 - 8:00	Coffee
8:00 - 10:00	Support Group Facilitator Techniques
10:00- 10:15	Break
10:15- 12:00	Support Group Facilitator Techniques with Elementary Group Emphasis
12:00- 1:00	Lunch

Afternoon

1:00 - 2:00	Question and Answer Period
2:00 - 2:15	Break
2:15 - 5:00	Closure and Re-Entry



USE, ABUSE  
AND  
DEPENDENCY



# CHEMICAL DEPENDENCY (Alcoholism)

What is Alcoholism?

1. It is a disease with formal recognition by the A.M.A. in 1956.
2. Chemical dependency is the *overwhelming urge* to use *regardless* of the consequences. As the illness progresses it produces a *negative impact* in all areas of the affected persons life.

family	physical
social	mental
legal	spiritual
financial	occupational

3. It effects *1 out of 10* drinking adults and *1 out of 5* drinking adolescents.
4. It is not a respector of social, cultural, ethnic, economic or religious boundaries.
5. It is the *largest* neglected health problem in America.
6. It is the *3rd* largest cause of death, preceded by cancer and heart disease.

What makes chemical dependency (alcohol or other mood-altering drugs) an illness?

1. The illness *can be described*.  
(It has symptoms which can be identified.)
2. The course of the illness is *predictable and progressive*.  
(It has stages and if left untreated/or not arrested it will become worse.)
  - A. Judgement
  - B. Behavior
  - C. Performance
  - D. Health
3. It is *primary*.  
(It is not a symptom of an underlying disorder.)
4. It is *permanent*.  
(It cannot be cured, but can be arrested.)
5. It is *fatal*.  
(If left untreated/or not arrested it will result in premature death.)

#### TRADITION —

- Social
- Cultural
- Religious

#### CONSUMPTION —

- National annual per capita consumption for Americans over 14 is 52 gallons.
- California is 5 gallons higher

#### REASONS —

- To feel *good*
- To relax
- To enhance (an already pleasurable situation)

### ALCOHOLISM &/OR CHEMICAL DEPENDENCY

is a

#### FAMILY ILLNESS

Just as the individual is effected by the illness and exhibits symptoms which can be identified, the family exhibits many of the same symptoms.

It is known as

#### CO-ALCOHOLISM

Just as the illness is *primary* in the person who is chemically dependent, it is also *primary* in the individual family members.

Each is effected by the growing dysfunction of the chemically dependent person.

## SYMPTOMS

Symptoms	C.D. (Behavior)	Co-C.D. (Behavior)
1. Character Change	a personality shift highs & lows, withdraws socially, rigid, less predictable, may change friends.	a personality shift high & lows, withdraws socially, rigid, less predictable.
2. Blackouts	functions while under the influence but has no recall.	less sure of what happened, blocks unpleasant events.
3. Changes in Chemical Use Patterns	changes own rules to accomodate drinking, goes against own value system.	may use with the c.d. person or stop using all together.
4. Preoccupation With The Chemical	has own supply, plans revolve around the chemical.	preoccupied with the use of the user, watches the user at social functions or may withdraw from same.
5. Physical Problems	problems with health - not identified with the use; hangovers or withdrawals; long range effects - liver damage, malnutrition, accidents.	psychosomatic illnesses; complaints; physical abuse.
6. Sneaky Behavior	hidden supplies, planning ahead.	finding hidden supplies, dumping, watching, checking.
7. Loss Of Control	loss of choice; chemical becomes primary; uses regardless of consequences.	feelings of helplessness, separation.
8. Defensive Postures	rigid personality; over does it; denial; anger.	takes on survival roles; denial; anger; withdrawal.
9. Tolerance	increase - hollow leg syndrome - decrease	increase/decrease of personal use.
10. May Use Alone	goes against cultural and social standards.	withdraws.

## KEY FACTORS

1. CHANGE IN LIFESTYLE —  
crazy, erratic behavior  
“that just isn’t George”  
trusting your gut feelings
2. TOLERANCE —  
what do they use now compared to what they were using then?
3. TROUBLE —  
social drinkers do not get into trouble - if they do they are not likely to repeat it.
4. CHANGE IN VALUE SYSTEM —  
the use costs them something they value - rules, ethics, relationships, self-worth.
5. DENIAL —  
defensiveness about use  
rationalizations, aggression, anger.

## PROGRESSIVE STAGES

1. EARLY —  
frequent relief use  
increased tolerance  
memory blackouts  
feelings of guilt
2. MIDDLE —  
gradual social withdrawal  
grandiose & aggressive behavior  
broken promises to stop using  
unable to control use  
persistent remorse  
decrease tolerance
3. LATE —  
work/school or money problems  
moral deterioration  
impaired thinking  
obsession with drinking  
neglect of physical needs  
physical deterioration

# SYMPTOMS OF CHEMICAL DEPENDENCY ALCOHOLISM

- I. Signs of alcoholism
  - A. Growing preoccupation
    1. Anticipation of drinking
      - a. During daytime activities
      - b. Vacation times (fishing trips become drinking binges)
      - c. Growing involvement in drinking activities (bar building, receipts)
    2. Growing need during times of stress
      - a. On job
      - b. Family and marriage problems
      - c. Emergencies
  - B. Growing rigidity in life-style
    1. Particular times for drinking during the day
    2. Self-imposed rules beginning to change (Saturday lunch)
    3. Will not tolerate interference during drinking times
    4. Limits "social" activities to those which involve drinking.
  - C. Growing tolerance
    1. "Wooden leg" syndrome (ability to hold liquor without showing it)
    2. Ingenuity around obtaining the chemical without others being aware
      - a. Gulp ing drinks
      - b. Ordering "stiffer" drinks (doubles, martinis, etc.)
      - c. Self-appointed bartender at social gatherings
      - d. Sneaking drinks
      - e. Drinking prior to social engagements
      - f. Purchasing liquor in greater quantities (cases instead of six-packs)
      - g. Protecting supply
        1. Purchasing more well before current supply is exhausted
        2. Hidden bottles (at home, car, on the job)
  - D. Loss of control
    1. Increasing blackouts
    2. Drinking a larger quantity than planned
    3. Binge drinking
    4. Morning drinking
    5. Repeated harmful consequences resulting from chemical use
      - a. Family
        1. Broken promises involving "cutting down"
        2. Drinking during family rituals (Christmas, birthdays)
        3. Sacrificing other family financial needs for chemicals
        4. Fights (physical) or arguments about drug usage
        5. Threats of divorce

- b. Legal
  - 1. Traffic violations (D.W.I., etc.)
  - 2. Drunk and disorderly
  - 3. Lawsuits caused by alcoholic impaired judgment
  - 4. Divorce proceedings
- c. Social
  - 1. Loss of friendship because of antisocial behavior
  - 2. Previous hobbies, interests and community activities neglected as a result of increased chemical use
- d. Occupational
  - 1. Absenteeism (hangovers)
  - 2. Lost promotions due to poor performance
  - 3. Threats of termination
  - 4. Loss of job
- e. Physical
  - 1. Numerous hospitalizations
  - 2. Medical advice to cut down
  - 3. Using alcohol as medication
    - a. To get to sleep
    - b. To relieve stress
- f. Growing defensiveness
  - 1. Vague and evasive answers
  - 2. Inappropriate affect around consequences of drug usage
  - 3. Frequent attempts at switching to other areas of concern

## II. Counselor should be

- A. Direct but not D.A. (District Attorney)
- B. Persistent but not threatening
- C. Aware of possible distortions due to sincere delusion
- D. Ready to seek out corroborating data from concerned person if person becomes highly defensive

# DRUG DEPENDENCY

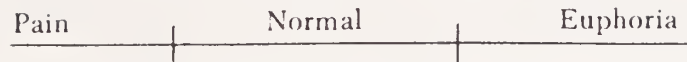
1. Signs of drug dependency
  - A. Growing preoccupation
    1. Anticipation of drug usage
      - a. Keeping track of prescribed times for dosage
      - b. Growing number of physical complaints which would require more drugs to relieve them.
    2. Growing need during times of stress
      - a. Begins to attempt to prevent stress ("It's going to be a rough day so I'll take a couple just in case.")
      - b. Minor family and marriage problems
      - c. Emergency situations
  - B. Growing rigidity in life-style
    1. Has particular times during day for drug usage, e.g., can't sleep unless he/she takes a sleeping pill
    2. Cannot go anywhere without supply of medication
    3. Will resent attempts made by others to limit drug intake
  - C. Growing tolerance
    1. Increasing dosage and/or number of different medications (drugs)
    2. Ingenuity around obtaining the drug without others being aware
      - a. Seeking out a variety of physicians and dentists for prescriptions but not informing them about each other
      - b. Attempting to get refillable perscriptions
      - c. Use of several drugstores
      - d. Using several drugs in combination for the synergistic effect e.g., a barbituate and alcoholic drink
      - e. Using the drug for longer than the original prescription called for
      - f. Protecting the supply
        1. Purchasing more before current supply is exhausted
        2. Storing pill bottles at home (suitcases), car, at work
  - D. Loss of control
    1. Increasing blackouts and memory distortion
    2. Larger and more frequent dosages than prescription calls for — using another person's prescriptions
    3. Continuous dosages, e.g., red pill every three hours, white pill every two hours, green capsule twice daily, etc.

4. Repeated harmful consequences resulting from drug usage
  - a. Family
    1. Frequent blackouts which lead to many "broken commitments"
    2. Inappropriate behavior during family rituals (Christmas, birthdays)
    3. Sacrificing other family needs for doctor appointments and prescriptions
    4. Changing family duties due to physical incapacity (increased time in bed, lack of motivation and drive)
    5. Drug induced mood changes create uncertainty and suspicion in family members
  - b. Legal
    1. Buying and/or selling illegal drugs
    2. Buying from illegal sources
    3. Traffic violations
    4. Disorderly conduct violations
    5. Lawsuits caused by chemically impaired judgment
    6. Divorce proceedings
  - c. Social
    1. Loss of friendship because of past antisocial behavior
    2. Previous hobbies, interests and community activities neglected as a result of increased drug usage
  - d. Occupational
    1. Absenteeism
    2. Lost promotions due to poor performance
    3. Demotions due to impaired and inappropriate behavior
    4. Loss of job
  - e. Physical
    1. Numerous hospitalizations
    2. Increasing number of physical complaints
    3. Physical deterioration due to chemical use
  - f. Growing defensiveness
    1. Vague and evasive answers
    2. Inappropriate affect around consequences of drug usage
    3. Frequent attempts at switching to other areas of concern

## II. Counselor should be

- A. Direct but not D.A. (District Attorney)
- B. Persistent but not threatening
- C. Aware of possible distortions due to sincere delusion
- D. Ready to seek out corroborating data from a significant other if person becomes highly defensive

# THE FEELING CHART



- I. **DISEASE:** Chemical dependency (alcoholism and/or drug addiction) is a disease. A disease has its own symptoms and is describable.
  - A. **PRIMARY DISEASE:** It is not a secondary symptom of something else.
  - B. **PROGRESSIVE DISEASE:** It gets progressively worse. The victim becomes physically, spiritually, emotionally and psychologically ill.
  - C. **CHRONIC DISEASE:** There is no cure. Recovery from the disease must be based on abstinence from mood altering chemicals.
  - D. **FATAL DISEASE:** The disease can only be arrested. If it is not arrested, the person will die from it.

## Progression of the Disease

### II. PHASE #1: LEARNING THE MOOD SWING (AUTONOMIC LEARNING)



- A. Learns that chemicals can provide a temporary mood swing in the direction of euphoria.
- B. Learns that chemicals will provide this positive mood swing every time they are used.
- C. Learns to trust the chemical and its effects.
- D. Learns to control the degree of the mood swing by regulating the quantity of the chemical intake.

### III. PHASE #2: SEEKING THE MOOD SWING



- A. Applies what was learned in Phase #1 to his/her social, cultural and life situation.
- B. Uses the chemical at the appropriate times and places.

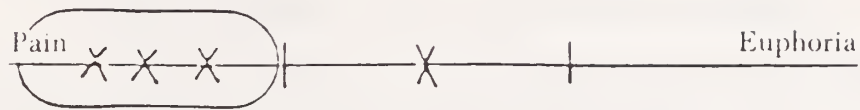
- C. Develops self-imposed rules about the use of the chemical and adheres to them, e.g., "I don't drink until after five o'clock."
- D. May suffer from physical pain (hangover) for an occasional overuse of the chemical but no emotional pain.
- E. Continues ability to control the times, quantities and outcome of all chemical using experiences.
- F. Social users remain in this phase. Victims of chemical dependency progress to Phase #3.

#### IV. PHASE #3: HARMFUL DEPENDENCY



- A. Begins to experience periodic loss of control over chemical use. Can no longer predict outcome once chemical use begins.
- B. These episodes result in behavior that violates the person's value system and in turn create the first emotional pain that the victim experiences.
- C. Spontaneous rationalizations arise and hide these feelings from the victim. This loss of insight becomes a growing delusion.
- D. Negative feelings about self remain unidentified and therefore are unresolvable. This results in a growing chronic emotional distress.
- E. Experiences growing anticipation and preoccupation with the use of the chemical.
- F. Lifestyle begins to change and revolve around the chemical.
- G. Specific times for chemical use are not established and rigidly held.
- H. Self-imposed rules that were developed in Phase #2 are now regularly being broken.
- I. Tolerance to the chemical increases causing the victim to develop more ingenious ways to get, use and keep the chemical, i.e., sneaking drinks, hiding bottles, etc.
- J. Projections of self-hatred onto others begin to occur.
- K. Victim's whole life is deteriorating as health, spirituality, emotional stability and interpersonal relationships become adversely affected.

V PHASE #4: USING TO FEEL NORMAL



- A. Using chemicals to survive rather than to feel euphoric.
- B. Blackouts occur more frequently.
- C. Tolerance built in Phase #3 breaks.
- D. Physical addiction can occur.
- E. Paranoid-like thinking is present.
- F. Geographic escapes are made.
- G. Loss of desire to live and a complete spiritual bankruptcy.

## SYMPTOMS OF ALCOHOLISM

The diagnosis of alcoholism is made primarily by obtaining a history of a drinking pattern that is predominantly **not** social drinking. Eliciting a history of **any** consequences that result from this nonsocial drinking pattern reflects the seriousness or the degree of the alcoholism.

The following list represents a nonsocial, or pathologic, use of alcohol.

1. **Preoccupation** with alcohol or the next opportunity to drink
2. **Gulping Drinks.** He usually drinks a double or downs the first couple drinks rapidly.
3. **Increased tolerance for alcohol.** The alcoholic can usually drink much more than others and still function relatively well.
4. **Drinking alone.** This includes drinking in bars, but alone.
5. **Use of alcohol as a medicine** for relief of tension or anxiety or as an aid to sleep.
6. **Blackout.** Drinking sufficiently such that the next morning brings amnesia for some of the events of the previous evening.
7. **Secluded bottle.** Having a bottle hidden in the home or somewhere in case a drink is needed.
8. **Nonpremeditated drinking.** Drinking much more than planned, or drinking differently from what one had planned.
9. **Morning tremors.** Fine tremor of fingers from overindulgence.
10. **Morning drink.** To help one over a hangover.

Most alcoholics today are unrecognized as such by themselves or by others. They are unaware that their drinking pattern is different, and they subconsciously defend themselves quite effectively from this knowledge. Therefore, considerable skill is needed in choosing the right questions to ask the suspected alcoholic in order to secure an accurate history. The following questions for each of the ten criteria listed above are suggested.

If 4 or more of the 10 criteria are fulfilled, this constitutes a pathologic or non-social drinking pattern and a positive diagnosis of alcoholism.

1. **PREOCCUPATION**

Do you ever look forward to the end of a day's work so that you can have a couple of drinks and relax?

Do you sometimes look forward to the end of the week so that you can have some fun drinking?

Does the thought of drinking sometimes enter your mind when you should be thinking of something else?

Do you sometimes feel the need to have a drink at a particular time of the day?

2. **GULPING DRINKS**

Do you usually order a double or like to have your first two or three drinks quickly?

Do you sometimes have a couple of drinks before going to a party or out to dinner?

3. **INCREASED TOLERANCE**

Do you find that you can often drink more than others and not show it too much?

Has anyone ever commented on your ability to hold your liquor?

Have you ever wondered about your increased capacity to drink and perhaps felt somewhat proud of it?

4. **USE OF ALCOHOL AS A MEDICINE**

Do you ever drink to calm your nerves or reduce tension?

Do you find it difficult to enjoy a party or dance if there is nothing to drink?

Do you ever use alcohol as a nightcap to help you get to sleep at night?

Do you ever use alcohol to relieve physical discomfort?

5. **DRINKING ALONE**

Do you ever stop in a bar and have a couple drinks by yourself?

Do you sometimes drink at home alone or when no one else is drinking?

6. **BLACKOUT**

In the morning after an evening of drinking, have you ever had the experience of not being able to remember everything that happened on the night before?

Have you ever had difficulty recalling how you got home after a night's drinking?

7. **SECLUDED BOTTLE**

Do you sometimes hide a bottle in the house in the event you may need a drink sometime?

Do you ever keep a bottle in the trunk of your car just in case you may need a drink?

8. **NONPREMEDITATED DRINKING**

Do you ever stop in to have two or three drinks and have several more than you planned?

Do you ever find yourself stopping in for a drink when you had planned to go straight home or someplace else?

Are you sometimes one of the last ones to leave a bar or a drinking party when you had planned to go home earlier in the evening?

Do you sometimes drink more than you think you should?

Is your drinking sometimes different from what you would like it to be?

9. **MORNING TREMORS**

Have you ever had the shakes or tremors of the hands after a night of drinking?

10. **MORNING DRINK**

Have you ever taken a drink in the morning to help you over a hangover?

If an examiner is not sure of the diagnosis of alcoholism after a review of the drinking history, then an exploration of the possible complications or consequences of drinking is necessary. As a result of drinking, a problem in any **ONE** of the following areas is all that is necessary to establish a diagnosis of alcoholism.

1. **MARITAL**

Does your wife (husband) think you drink too much?

Does your wife (husband) object to your drinking?

Has your wife (husband) ever threatened to leave you because of your drinking?

2. **ECONOMIC**

Do you sometimes drink even though you cannot afford to?

3. **INDUSTRIAL**

Have you ever missed work because of a hangover?

Have you ever lost a job because of drinking?

Has drinking ever caused you to be less efficient in your work?

Have you ever been threatened with loss of a job because of drinking?

4. **PHYSICAL**

Has a doctor ever told you to cut down or stop your drinking for any reason at all?

Have you ever been hospitalized because of drinking or from a complication due to your drinking?

5. **SOCIAL**

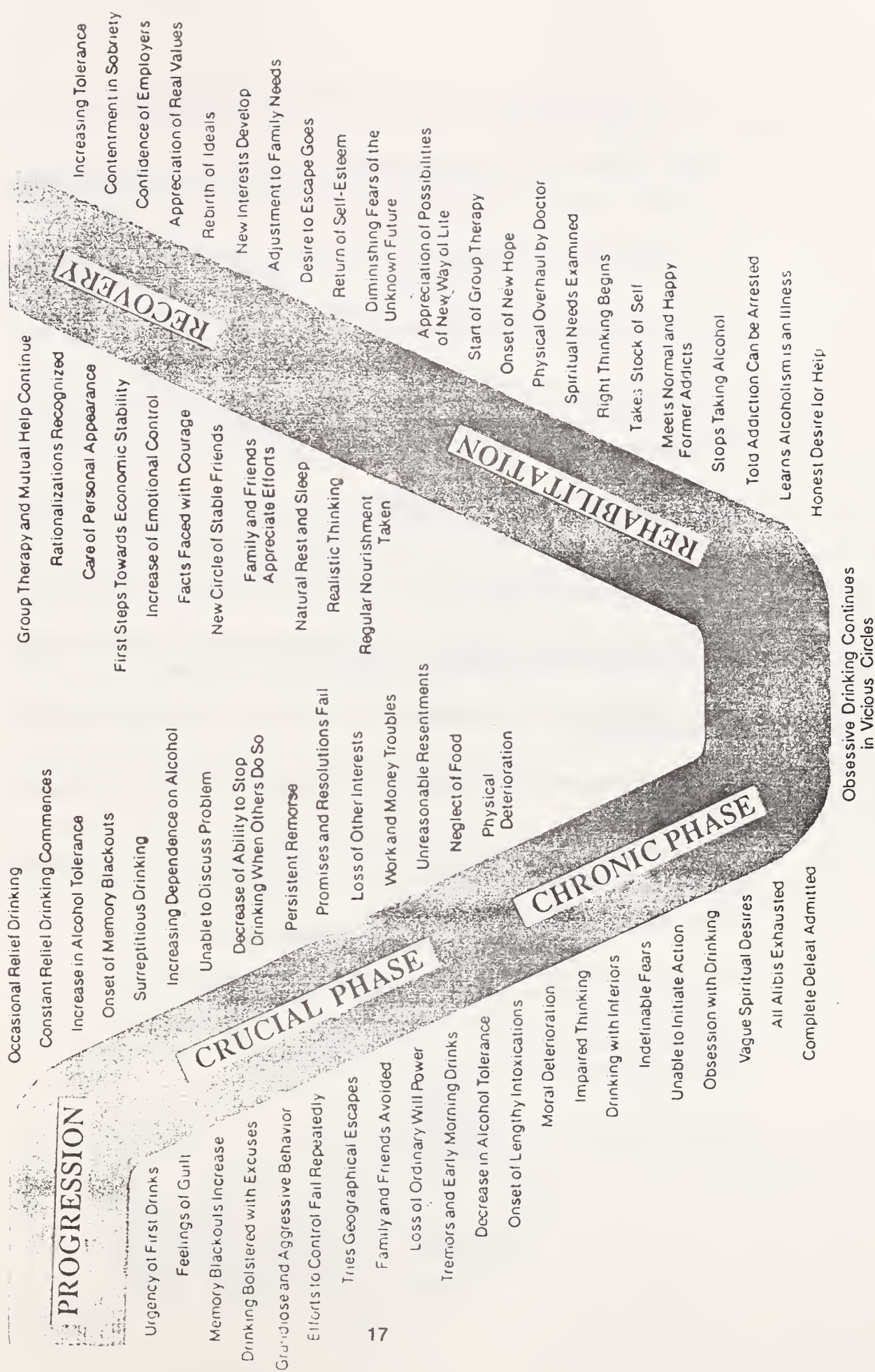
Do you have a very definite preference to associate with people who drink rather than with those who do not?

Do you sometimes do things while drinking that you are ashamed of later?

Has drinking become so important or time consuming that previous hobbies or interest are neglected?

# The Progression and Recovery of the Alcoholic in the Disease of Alcoholism

Enlightened and interesting way of life opens up with road ahead to higher levels than ever before



## Fact Sheet on Alcoholism Among Adolescents

There are more than 3.5 million adolescents who are alcoholics.

Three out of four teenagers drink alcoholic beverages, and one of every five become drunk at least once a month according to a new government report on alcoholism.

Children as young as nine years old are reported to be showing early signs of problem drinking.

Alcohol consumption is more prevalent among teenagers along the East and West coasts and at college campuses. Ninety percent of the adolescent population in these areas drink to some extent.

Alcoholism is common among upper middle-income families. Teenagers of affluent homes more often exhibit behavior which leads researchers to classify them as problem drinkers. Ninety-five percent of all affluent homes have open bars.

More than 70 percent of all teenagers nationwide drink to some extent.

Drinking is a socially accepted activity. More than 13 percent of all high school students are encouraged by their parents to drink alcohol in their homes.

The Parent-Teacher Association revealed that drinking among school children has doubled since 1958.

One college instructor: "I firmly believe that colleges act as the training ground for alcoholics."

Drunken driving and public drunkenness have increased 50 percent in the past three years on the nation's college campuses.

**Indirect problems related to alcoholism and the adolescent.**

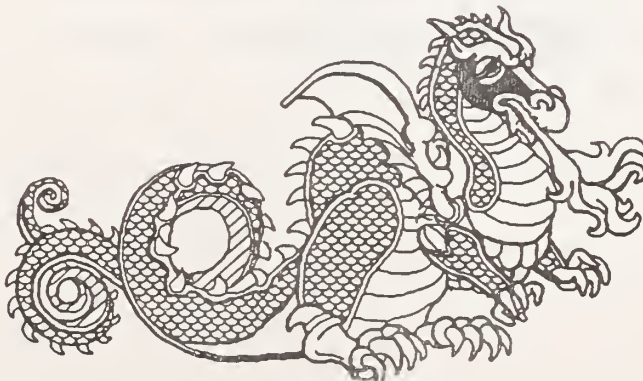
Approximately 63 percent of all reported child abuse cases are alcohol-related.

According to a recent Gallup Poll: "As many as half of all parents say that they set no guidelines regarding the use of alcoholic beverages by their children," thus encouraging a permissive life-style conducive to drinking.

The social effects of alcoholism are passed down from one generation to the next in some cases. Children of alcoholics are reported to be 50 percent more likely to marry an alcoholic.

## BEHAVIOR SIGNS, IN THE CLASSROOM OF AN ADOLESCENT THAT MAY BE ABUSING DRUGS/ALCOHOL

1. BLOODSHOT EYES - This is not always a reliable diagnostic tool, but a sign for you to be on the look-out.
2. SMELL OF ALCOHOL OR POT - This could be the smell of recent use or the aftereffects of continued use.
3. NOT RESPONDING IN CLASS - Lack of concern regarding class and school in general. A student that is difficult to motivate.
4. SKIPPING CLASS AND/OR SCHOOL - This usually comes out in chronic skipping of classes or the entire school day.
5. CONSTANTLY LATE FOR CLASS - Student usually has poor excuses for being late, and may come late with other students.
6. WORK NOT COMPLETED - Again, poor excuses for not getting work finished on time or at all.
7. DRUG RELATED JEWELRY, CLOTHING - Clips, spoons, t-shirts with drug related messages; also may show up as drawing drug related material on clothing, books desks and self.
8. SITTING IN THE BACK OF CLASS - Sleeping, day dreaming, laughing, lots of talk regarding drugs or parties.
9. VERBAL ABUSE - This is usually directed towards teachers, and/or anyone that represents authority.
10. LEAVING SCHOOL GROUNDS - This happens usually during the lunch period or a study hall.
11. VANDALISM - To school property, or teacher's property.
12. ABSENTEEISM - Excuses are usually forged, or student may make many appointments to see nurse or complain of being ill.
13. DROP IN GRADES - This usually comes as a drastic drop in grades.
14. PEERS - Student will hang out with a crowd of known trouble makers, or known users



## AN ADDITIONAL LIST OF BEHAVIORS TO WATCH FOR -

Defensive  
Withdrawn, seclusion, loner  
Changes in behavior, friends  
Grades, weight, appearance  
Hypersensitive  
Avoidance  
Parental or peer concerns  
Physical complaints  
Dramatic attention getting  
Manipulation  
Apathy  
Incoherence  
Others reporting concern  
Drug/alcohol use  
Unrealistic goals  
Crying  
Job problems  
Hanging around drug culture  
Exchanges of money  
Court appearances  
Depression  
Mood swings  
Family problems  
Unusual amount of physical injuries  
Sudden popularity  
Older age social group  
Constantly borrowing money  
Extreme dissatisfaction with school  
Blaming  
Denying problem areas  
Frequent visits to nurse, counselor, principal  
Time disorientation  
Runaway  
Vomiting in class  
Inconsistent behavior  
Inability to reason

## **-PARENTS-**

### **BEHAVIOR SIGNS OF AN ADOLESCENT WHO IS POSSIBLY ABUSING DRUGS/ALCOHOL**

1. A DROP IN GRADES - This could be a slow decrease in the past six months to a year, or a sudden decrease.
2. SWITCHING FRIENDS - Are you seeing a different set of friends around the house? More friends that you object to? Not meeting any friends?
3. EMOTIONAL HIGHS AND LOWS - Easily upset, emotional state changes rapidly, doesn't seem as happy as she/he used to.
4. DEFIANCE TO RULES AND REGULATIONS - Pushing limits around the house, not doing chores around the house.
5. BECOMING MORE SECRETIVE - Not sharing any, or very little of their personal life.
6. LOSS OF INITIATIVE - Less energy, sleeping more than usual.
7. WITHDRAWING FROM FAMILY FUNCTIONS - Camping trips, church, meals.
8. CHANGE IN PHYSICAL HYGIENE - Becoming more sloppy, wearing same clothes.
9. NOT INFORMING YOU OF SCHOOL ACTIVITIES - Open houses, teacher conferences, warnings, suspensions.
10. MANY EXCUSES FOR STAYING OUT LATE - Not coming home on time, not coming home at all, constant excuses.
11. ISOLATING THEMSELVES - Possibly spending a lot of time in their rooms.
12. SUSPICION OF MONEY OR ALCOHOL MISSING - From parents or brothers, sisters.
13. SELLING POSSESSIONS - Clothing, records, gifts - seems to have money - no job.
14. FEELING MANIPULATED AND BARGAINED WITH - Playing parents against each other.
15. WEIGHT CHANGES - Drastic loss or gain.
16. SHORT TEMPERED - Becomes angry often, short fuse.
17. LEGAL PROBLEMS - DUI, curfew, other troubles with police.
18. DEFENSIVE - When confronted on behavior or other concerns.
19. COMING HOME DRUNK OR HIGH - Smelling of pot or alcohol, giddy, slurred speech.
20. FINDING PARAPHERNALIA - Papers, pipes, clips, drugs, bottles

Spotting any of these behaviors may be a serious concern; before coming to any conclusions, consult either your school counselor and/or drug/alcohol counselor.



# FEELINGS AND DEFENSES



## FEELINGS AND DEFENSES

The purpose of this paper is to discuss the assumptions and techniques we are using in conducting support group. To begin with, let's look at some of the similarities within our group. In addition to our problems with chemicals we have two things in common. First, we each tried our own "Do It Yourself" program in an effort to change ourselves. The second similarity is that we may have failed. A basic assumption of support groups is that a major reason for this failure is that our most determined efforts can't change what we can't see, and that there is a great deal that we are not seeing clearly.

For this reason our goal in group is:

TO DISCOVER OURSELVES AND OTHERS AS FEELING PERSONS  
TO IDENTIFY THE DEFENSES THAT PREVENT THIS DISCOVERY

while change is the ultimate goal, our immediate purpose is to more accurately see what needs change. This requires seeing ourself - Discovering Ourself and at a feeling level.

In examining our purpose, one of the things that stands out is our emphasis on feelings. We stress feelings for several reasons. First of all, our behavior in the past has been so opposed to our value system that considerable feelings of remorse and self-loathing have been built up. It appears that we have accumulated a pool of negative feelings and walled them off with a variety of masks or defenses that prevent this discovery. This began with mild disapproval of ourself, then growing remorse, and, finally, a deep self-loathing. Statements such as: "I am no damn good" or "The world would be better off without me" reflect these negative feelings and attitudes. It is important to be in touch with these in order to take the First Step of the Alcoholics Anonymous Program where: "We admitted that we were powerless over alcohol - that our lives had become unmanageable."

Being in touch with the hostile feelings we have toward ourselves and the sense of helplessness and hopelessness that accompany them, make the First Step a moving description instead of simply an abstract theory. We feel the powerlessness and the unmanageability. One of the important functions of group is to help us identify the defenses that prevent this discovery. We will say more about this wall of defense later on.

Another reason for stressing feelings is that many of the character defects that have disabled us for years are reflected in our feeling states or attitudes. As a result of the conflict between our value system and our repeated chemically induced behaviors, we have formed rigid negative feeling states called attitudes toward ourselves and others. Most of us have become one or more of the following persons: Hostile, Resentful, Angry, Self-Pitying, Fearful, Feigning, Phony, Arrogant, Superior. While these are represented as feelings, some have become so thoroughly a part of us as to be attitudinal in nature. They substantially color the way we see life and react to it. No longer are we persons who simply feel resentment; we are resentful persons. We may discover that we are not simply persons who feel self-pity; but that we have become self-pitying persons. What was once a feeling has now hardened into an attitudinal posture - a character defect. If we are to change, we must first become ourselves at this feeling level.

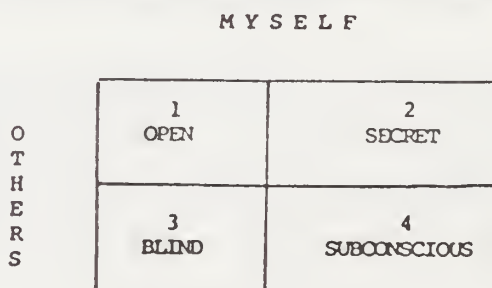
Most of us are badly out of touch with our feelings, particularly the ones we have been describing. But as you will see, it is not just these negative feelings that are hidden and controlled. Our positive feelings of joy and love are also locked away by the defenses that seek to hide the negative feelings from view. It appears that our defenses are not selective. The man who has hidden away his anger is also crippled in any spontaneous display of affection or gratitude as well. While the majority of our focus in group is on identifying our destructive negative-feeling selves, the acceptance of these feelings frees the positive ones as well. "I never could tell anyone I really liked him before, unless I was drinking" is one example of this phenomenon.

Most of us have ignored our feelings for years in an effort to see the facts. In group Feelings are Facts. "How does that make you feel?" is a question asked frequently to help us focus on these Facts.

Since our feelings are new to most of us, let's look at the ones we use everyday: Mad, Sad, Glad, Afraid, Ashamed, Hurt.

Our immediate purpose is to Discover and Identify in order to see clearly who I am and what needs change. Acceptance of What Is precedes change. Seeing and accepting What is is very difficult, however, because we don't know that we don't know. We are in many ways blind and self-deluded, but we insis that: "I know who I am and where I'm going" - or - "I know what's best for me." We are deluded and we don't know it. If fact, most of us deny it. This is what allows us to fall back into the same destructive behaviors again, not having learned anything from the last one. How many times has a friend or relative said: "I saw you building up to it, but you insisted everything was O.K.!" The assumption that self-delusion is a fact is basic to group.

The way we illustrate this self-delusion is with the Johari Window:



The Window's 4 panes represents four aspects of our total self. As the diagram indicates, only the top 2 panes are visible to myself. #3 and #4 are hidden from my view. This is descriptive of the self-delusion that keeps me from seeing what I'm really like and allows my slow disintegration to continue with only a slight, if any, recognition on my part of how bad things have become. A more accurate picture of myself is essential to recovery.

Window #1 is open. This is visible to Self and to Others and contains material I am willing to share with you - my interests, vocation, and virtues, to name a few. This is open information about myself.

Window #2 is secret. I know things about me that I don't want you to know. I fear the loss of esteem if you see me as having such feelings as hostility, suspicion, inferiority, resentment, or self-pity. Revealing these feelings is called leveling. I level with you when I take the risk of letting you really know me by spontaneously reporting my feelings. Leveling is one of the two most important techniques in self-discovery.

We are blind to Window #3, and yet it is seen by others. The tone of our voice, the tilt of our head, tell other things about us that we don't see. Many times a perfect stranger can see more in us in half an hour than we discovered in years of self-examination. When someone tells us how we appear to them, they are confronting us. Confrontation is the second vital technique in breaking through self-delusion to self-discovery.

The existence of the large blind area illustrated by Window #3 means that we are dependent on others taking the risk of confronting us with this material if we are to ever come to know it. "It takes at least 2 to know 1."

Window #4 is subconscious and not visible. While leveling and confronting often result in a glimpse into the unconscious, this is a bonus and not a goal of group.

## CONFRONTATION

It takes courage to risk confronting. We have all traded our honesty for the approval of others in the past. However, if we care about our fellow group members, and if we want them to be honest with us in return, we will present them with our picture of them.

Confrontation is defined as: Presentating a person with himself by describing how I see him. Confrontation is most useful when spoken with concern and accompanied with examples of the confronted behavior or data.

"You seem self-centered to me because you only talk about yourself"...

"You seem hostile because of the sarcastic answers you give"...

"Your voice sounds so sad I see you feeling sorry for yourself"...

"Your face is so red you seem very angry"...

"John, each time Joe confronts you, you explain yourself instead of leveling with him. How do you feel about what Joe told you?"

OR

"John, you go into a long silence after each confrontation instead of leveling. How are you feeling when you withdraw in silence?"

For the most part defenses, including attitudinal postures, are unintentional and automatic shields against a real or imagined threat to our self-esteem. By pointing out the defenses we are using, we have a better chance of letting down this wall that is locking others out and keeping us prisoners. This blocks our getting close to others as well as our getting closer to ourselves. coming to recognize these blocks to self-discovery may enable us to look behind them to discover the feelings concealed from view. Long explanations may hide feelings of inadequacy and guilt. Since defenses and attitudinal postures do hide us from ourselves, as well as others, it is important to identify them. A lot of this is new, so while you are getting used to it , just TRUST YOUR IMPLUSES. Stipntaneous expressions tend to be much more honest. It is more helpful to be Revealing than to be Right.

Most of us tend to think we already know ourselves and are afraid of looking badly, so it is hard for us to take the risk of being revealing and genuine. But what have we really got to lose? Since we can't change something until we really see it and accept its existence, we should ask ourselves: "Do I really accept something if I keep it a secret?" Risking openness is the key. When you are tempted to withdraw into silence, remember that we are all in the same boat, and a common feeling of everyone when he is introduced to group is fear.

Frequently, in place of confronting a person with some data that we have observed (what they said - how they look - or sound, etc.) we make the mistake of guessing - of asking questions, and advice giving.

"I bet you fight a lot with your wife."

"Did your parents raise you very strictly?"

A guess or a question is not confrontation.  
The other mistake is advice giving in place of confronting:

"Don't let people walk all over you so much"...

To state this as confrontation would be:

"You seem like a doormat the way you let people walk all over you."...

This way we are not playing God by advising, but we are letting the person see himself from another point of view and trusting him to seek advice if he wants it.

Confrontation is descriptive of what we have observed in the person we are confronting. Guesses, advice, or discussions about something we have not witnessed is not confrontation. In a sense, when we confront, we hold up a mirror to let another person know how he appears to us.

We are most useful as confronters when we are not so much trying to change another person as we are trying to help him see himself more accurately. Change, if it comes, comes later when the person chooses it and enlists the spiritual help that the 6th and 7th Steps of the A.A. Program describe.

Picture a gardener preparing a proper environment within the soil so that the seeds he plants may receive the gift of growth from the Power greater than himself. Imagine a physician cleaning a wound to provide an environment to receive the gift of healing. The change we are all seeking might be more correctly labeled healing or growth and, while it is largely a gift of a Power greater than ourselves, the necessary environment for the gift is an honest picture of who and what we are like now. Because of our egocentric blindness and self-delusion, we are all dependent on others for that completed picture. Confrontation provides it.



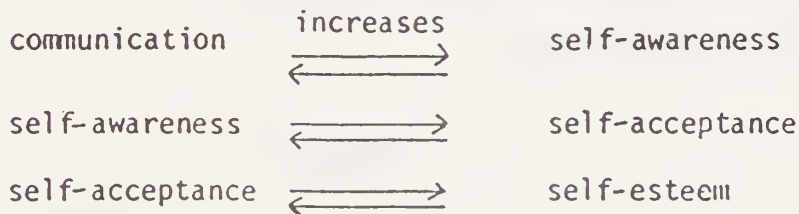
## Notes on Communication: Feelings and Defenses

Self Awareness increases our choices

1. to change or not to change
2. to communicate effectively or not effectively
  - a. creating/maintaining/altering/terminating a relationship
  - b. cannot NOT communicate. We are communicating
    - with or without words
    - with or without action
    - directly or indirectly

Both change and communication are limited by the extent of our SELF-AWARENESS.

∴ Self awareness is a critical factor in



Acceptance of what is precedes CHANGE

∴ want to move from delusion to self-awareness

### Self delusion

each of us has a degree of delusion

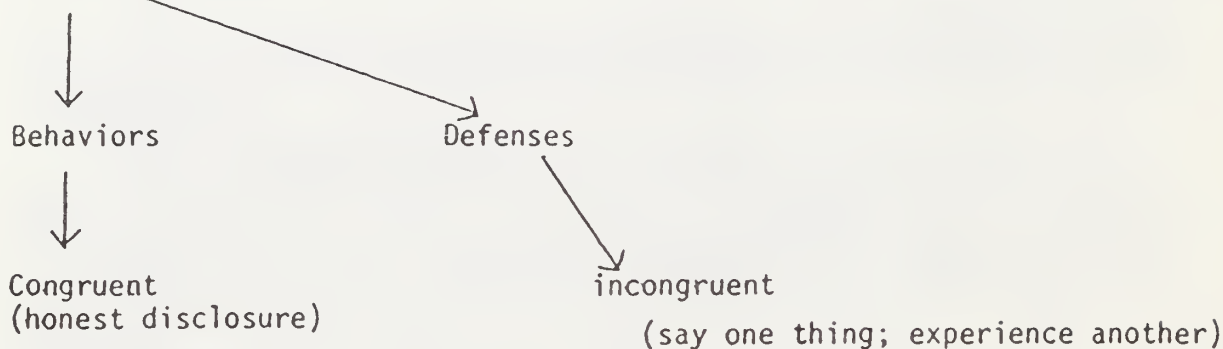
Johari Window

① Open	② Secret (suppression)
③ Blind (repression)	④ Unconscious ("why")

- 1 open - visible to self and others
- 2 secret - we know but hide from others
- 3 blind - hidden from self but others see
- 4 unconscious - hidden from self and others  
(why we need feedback from others)

- 1 open - visible to self and others
2. secret - we know but hide from others
- 3 blind - hidden from self but others see
- 4 unconscious - hidden from self and others

Feelings: open; secret; blind; unconscious



Useful solutions to issues emerge out of high awareness  
congruently disclosed and acted upon.

### Feelings

sad  
 mad  
 glad  
 hurt  
 guilt  
 shame  
 fear  
 inadequate

### Defenses

justify	threaten
intellectualize	joke
sarcasm	smiling
evading	pleasing
switching	generalizing
silence	denying
attaching	judging
minimizing	quibbling
withdrawing	blaming

etc.

Group Process: assists us  
 1. to become self-aware  
 2. to help others become self-aware

### A. Leveling: share, report state

1. Reveal feelings in windows
2. congruent
3. to respond w/o leveling is to go back to window 2 or 3.  
 (secret/blind)
4. cover feelings with defenses

Defenses are automatic shields against real or imagined threats to self-esteem. They block self-awareness and self-acceptance. They keep us from getting close to self and others.

- B. Confrontation: presenting a person with his/herself by describing how you see the person
1. It takes courage
  2. express with care and concern and specific data
  3. non-judgmental
- C. Feedback: a way of helping another person to consider changing his/her behavior
1. information re: how he/she affects you
  2. descriptive: receiver free to accept or reject it
  3. specific - not general
  4. directed toward behavior the receiver can change
- D. Active Listening: Total Concentration  
not thinking of a response  
not fidgeting or interrupting

## LEVELING

To respond openly to being confronted is to level. We level when we take the risk of being known by spontaneously reporting our feelings. For example: We level when we let someone know we are hurt - or afraid - or that we are angry.

Using these feelings as an example of leveling is probably useful for two reasons. Anger, bottled up, or fear that is kept hidden seem to lead to more relapses than any other feelings. Also, anger and fear (along with affection) are usually the hardest feelings for us to report. Frequently, people make the mistake of assuming that the purpose of group is to make someone angry. Anger is an important feeling. But it is only one feeling among many that we want to discover and level with.

If, instead of leveling, we respond without naming a feeling, we are hiding. The ways we hide our feelings are many, and we call them defenses. Each defense prevents us from being known. One of the most helpful things that the group can do is to help a member identify his defenses.

Defenses which we all use to some extent are:

Rationalizing	Minimizing
Justifying	Evading, dodging
Projecting	Defiance
Blaming, accusing	Attacking, aggression
Judging, moralizing	Withdrawing
Intellectualizing	Silence
Analyzing	Verbalizing, talking
Explaining	Shouting, intimidating
Theorizing	Threatening
Generalizing	Frowning
Quibbling, equivocating	Glaring
Debating, arguing	Staring
Sparring	Joking
Questioning, interrogating	Grinning, smiling, laughing
Switching	Protecting
Denying	Agreeing
Smug, superior or arrogant	Complying

Try leveling with that feeling of fear for a starter and discover how that makes you feel. You will probably find, as others have, that when you report a feeling you modify it. Keeping it a secret seems to increase its power. If we don't begin now to risk being genuine and self-revealing, when will we ever really do it?

## FEELINGS

If we want to be loved we must reveal ourselves. If we want to love someone they must allow us to know them.

As obvious as this may be many of us go through life avoiding such disclosure. In fact, most of us practice concealment by playing roles. We claim to have certain feelings which we actually do not have, we profess to be loving when we're full of hostility, calm -- when in reality anxiety is nearly overwhelming us, and to believe in things when in truth we do not.

Even with those persons we care most about we share little of our true feelings, beliefs or needs. Perhaps because we want so much to be loved we fear the truth that may come with openness and consequently we present ourselves as the sort of person we think would damage that image.

Another reason we try to conceal ourselves is the fear of change. For most people change is frightening and we want to think of ourselves as "constant". We've molded our image and seem to believe we are all that we ever could be, when in reality our needs, desires, goals, values, behavior and feelings change with experience and age.

Still another reason we fail to expose our real self is that we don't really know how, we've never been taught how, in fact, we learned more about how to conceal our true identity. The result being that we continue to accept and play our roles. And our society encourages, in fact pressures us, to suppress all of the emotions and characteristics that it considers "unacceptable". Of course, there are times when honest leveling isn't possible and role playing is appropriate in the social system we must be a part of and which requires certain discipline. The key is "appropriateness"---to be private when we wish, but also able to be honest and open, without fear. We are human beings, alive, always growing and full of feelings ---feelings that may be labeled "comfortable" or "uncomfortable" "pleasant" or "unpleasant" but not "good" or "bad". Feelings are perhaps our most personal possessions and when they are not managed appropriately they can be devastating. We must be able to identify our feelings, accept them as an integral part of us and manage each one as it comes, avoiding suppression when possible, and then go on to the next feeling---for with certainty, it will come.

F. G. Wishart 2/15/74



## THE COURAGE TO BE IMPERFECT

FROM A SPEECH BY  
DR. RUDOLF DREIKURS

I have chosen today only one aspect of psychological importance to present to you for your thought and consideration: The subject of "The Courage to be Imperfect." In this one subject and topic it seems that a number of basic problems facing us come to the fore. In this subject and topic we deal with our culture; we deal with the need for a re-orientation in a changing culture; we deal with the basic problems of education; and, finally, we have here an area where we may even learn eventually to deal more effectively with ourselves.

We can well see that perfectionism is rampant today. A great many people try so hard to do right and to be right. Only a few psychiatrists are perhaps catching on to the implications of such a desire which has highly depreciated our fellow men, our society. So it may perhaps be presumptuous to ask what right do we have to interfere with the people's desire to be right and to do right and to become perfect. In a certain way we may even consider the term and the notion of God as the ideal of perfection. The question of justice is intrinsically linked to the demand to have the right--the right distinguishes from wrong--punishing for the wrong and perhaps praising the right. Moral standards are impossible without a clear distinction between right and wrong, and stimulating efforts toward the right.

Let us perhaps first state the one thing. Right and wrong are judgments. In many cases they are valueless judgements. The right and wrong can be clearly defined only when we have absolutes--only in an absolutistic way can we say, "that is right" and "this is wrong". And there are many people who out of the tradition of our culture are still looking for this absolute. Truth is an absolute: Something is either wrong or right, true or false. That is how we think. And perhaps that is the way we have to act.

What we don't realize so often is that all of these absolutes are gone in a civilization which has become democratic. Absolutes are only possible if we have authority which decides what is right and wrong. As far as we are concerned in our private lives we have become such an authority because each one of us determines for himself what is right and what is wrong; what is true and what is false. But when it comes to a generalized statement, then we run into troubles. What is right for the one may be wrong for the other one. What is good for one, what is beautiful for one, may not be so for another one. And as we are losing the authoritarian order in our society we lose more and more the authorities which establish absolute judgments. The entire world where even science has to make this adjustment--mechanistic science in the 17th and 18th centuries was still under the impression that one can easily distinguish between truth and false--the truth must be found, despite the warning of philosophers like Kant that the real thing can't be seen, that everything is approximation.

So we find today that right and wrong are also approximations. We can only come closer to the right and see clearer something which is not so right. But the absolute right does no longer exist. The same way as we can never again dream about finding the absolute truth. Every truth is approximate, for the time being; until a better truth is found.

I have found many, many people who try so hard to be good. But I have failed yet to see that they have done so for the welfare of others. What I find behind these people who try to be so good is a concern with their own prestige. They are good for the benefit of their own self-elevation. Anybody who is really concerned with the welfare of others won't have any time or interest to become concerned with the question of how good he is.

To explain a little bit further I might perhaps present to you two ways of movement on the social scene; two ways of working, of applying oneself. We can distinguish them as the horizontal plane and the vertical plane. What do I mean by that? Some people entirely and others in certain areas move on the horizontal plane. That means that whatever they do they move toward others, they want to do something for others, they are interested in others--they merely function. That is

clearly distinguishable from another motivation by which people move on the vertical plane. Whatever they are doing, they are doing it because they want to be higher, they want to be better.

As a matter of fact, improvement, contributions, can be done in either way: There are people who do something well because they enjoy doing it; and others who can do something well because they are so glad to prove how good they are. Even human progress probably depends just as well on the contributions of those who move on the horizontal and on the vertical plane. Many have done tremendous benefit to mankind actually motivated only by the question of proving how good they are--looking for their own superiority. And others have done a great deal of good--as we call it, in an unselfish way--without consideration of what they may get out of it.

And yet there is a fundamental difference in the way things are accomplished, whether you move on the horizontal or the vertical plane. When you move on the vertical plane you go up; you increase your knowledge, you increase your status, your respect, your prestige--perhaps even your money. But at the same time nobody who moves on the vertical plane is ever only moving up. He is constantly moving up and down, up and down. One day when he does something good he moves a few notches up; next moment when he makes some mistake he moves back down again. Up and down, up and down. That is exactly the plane on which most of our contemporaries move today. The consequences are obvious. A person who moves on the vertical plane can never be sure that he is high enough, never be sure the next morning that he is not coming down again. Therefore he has to live with tension and fears and anxieties. He is constantly vulnerable. As soon as something doesn't go well, down he goes--if not in the opinion of others, then in his own.

Quite different is the movement on the horizontal plane. The person who moves on the horizontal plane is constantly moving ahead in the direction he wants to move. He doesn't move up but he moves ahead. When something goes wrong, he considers what's going on, tries to find a way around, tries to remedy it. He is merely motivated by interest. If his motivation is very strong, he may even have enthusiasm. But he doesn't think about his own self-elevation; he is interested in functioning instead of being concerned with his status or prestige.

And so we see how on the one side, on the horizontal plane we have the desire to be useful. On the vertical plane we have the desire for self-elevation with the constant fear of making mistakes. And yet, most people today, stimulated by our general social values of social competition, are entirely devoting themselves to the problem of their own value and self-elevation--never sure that they are good enough, never quite sure that they will measure up; even though in the eyes of their fellow man they may be highly successful.

Now that points us, then, to a crucial question for those who are so concerned with self-elevation. The crucial question is the problem of mistakes--making mistakes.

Perhaps we first have to state a little bit clearer why people become concerned--badly concerned--with the danger of making a mistake. We can perhaps refer first to our tradition, to our cultural tradition. In an autocratic society, making a mistake is unpardonable, intolerable. The king, the master, never makes a mistake because he has the right to do as he darn well pleases. And there is nobody who can tell him he has done something wrong except at the danger of losing his head. Mistakes are only possible to be made by subordinates. The only one who decides whether a mistake is made is the boss.

Making a mistake means thereby nonconformity with the demands: "As long as you do as I tell you there is no mistake possible because I am right. I say so. Making a mistake therefore means that you don't do what I tell you. And I won't stand for that. If you dare to do something wrong--that means different from what I tell you--you can count on the worst possible punishment. And in case you have any delusion that I might not be able to punish you, there will be somebody higher than me who will see to it that you will be punished. A mistake is a deadly sin. Making a mistake incurs the worst possible fate. That is a typical and unnecessary authoritarian concept of cooperation: Cooperation means doing as I tell you.

It seems to me that our fear of making a mistake has a different meaning. It is an expression of our highly competitive way of living. Making a mistake becomes dangerous not because of the punishment--of which we don't think--but because of the lowering of our status, of the ridicule, of the humiliation, which it may incur: "If I do something wrong and you find that I am doing something wrong, then I am no good. And if I am no good, then I have no respect, I have no status. Then you might be better than me. Horrible thought!"

"I want to be better than you because I want to be superior." But in our present era we haven't so many other signs of superiority. Now the white man no longer can be so proud of his superiority because he is white; and the man because he is a man and looks down on the woman--we don't let him do that any more. And even the superiority of money is another question because we can lose it. The Great Depression has shown it to us.

There is only one area where we can still feel safely superior: When we are right. It is a new snobbishism of intellectuals: "I know more, therefore you are stupid and I am superior to you." The superiority of the moralists: "I am better than you; therefore I am superior to you." And it is in this competitive drive to accomplish a moral and intellectual superiority that making a mistake becomes so dangerous again: "If you find out that I am wrong, how can I look down on you? And if I can't look down on you, you certainly can look down on me."

That is how human relations of today are--in our community just as much as in our families; where brothers and sisters, husbands and wives, parents and children look down on each other for doing wrong and each one trying to prove so desperately that he is right and the other is wrong. Except, those who don't care any more can tell you, "You are right, you think, but I have the power to punish you; I will do what I want, and you can't stop me." But of course, while we feel defeated by a little child who is our boss and who does what he pleases, we still have one thing left: At least we know we are right and he is wrong.

When you try to be cautious, when you use your judgment, you are not thinking about "I shouldn't make a mistake;" you are merely trying to do what the situation would warrant. But anybody who is fascinated by the possibility of making a mistake is most liable to make one. Preoccupation with the danger of making a mistake leads you smack into it. The best way of avoiding a mistake is doing your part and don't think about the possibilities of making mistakes.

Actually, all these people who try so desperately to avoid mistakes are endangering themselves. The reason for that is twofold. First, when you think about the mistake which you might make, you do to yourself the greatest of harm by discouraging yourself. We know that discouragement is the best motivation for doing something wrong. In order to do something right, one has to have confidence--self-confidence. When you think about the mistake you might make you express your lack of faith in yourself, your lack of confidence in yourself. And, consequently, out of this discouragement we are more prone to make a mistake.

But there is another psychological mechanism that makes concern with mistakes so dangerous. We know today that everybody moves in accordance with his expectations. When you expect to do something, are really convinced you will do it, you are more strong to to it. You may not always do it because there may be other factors involved. But, as far as you are concerned, when you expect to behave in a certain way, you are most prone to behave in this way.

I don't know how many of you have had the experience when you learn to ride a bicycle or to ski. I learned both and I had the experience in both. The first time I am alone on a bicycle in the middle of the street, completely empty except for the one thing which stands there in the middle; it is much more difficult to hit the one thing instead of going around left or right, but you will hit it. Because you expect to hit it. The same way when you are on skis and there is a tree here. Why should you just hit this one tree? But you do, the first time you are on skis, because that is what you expect from yourself in what you are doing. We are moving ourselves in line with what we anticipate and it is therefore anticipating the danger of mistake that makes us more vulnerable.

The mistake presents you with a predicament. But if you are not discouraged, if you are willing and able to take and utilize your inner resources, the predicament is only stimulating you to better and more successful efforts. There is no sense crying over spilled milk.

But most people who make mistakes feel guilty, they feel degraded, they lose respect for themselves, they lose belief in their own ability. And I have seen it time and again: The real damage was not done through the mistakes they made but through the guilt feeling, discouragement, which they had afterwards. Then they really messed it up for themselves. As long as we are so preoccupied with the fallacious assumption of the importance of mistakes, we can't take mistakes in our stride.

Now let's see what consequences these facts have on education and on living with oneself. It is my contention that our education today is very largely what I call mistake-centered. If you could enumerate the various actions of a teacher in a class and could enumerate for every hour and every day what she is doing with the children, you would be surprised how many of her actions are directly dealing with mistakes which children have made. As if we were obliged to primarily correct or prevent mistakes.

I fear that in the majority of tests given to students the final mark does not depend on how many brilliant things he said and did, but how many mistakes he made. And if he made a mistake he can't get a hundred regardless of how much he has contributed on other parts of the examination. Mistakes determining the value. In this way we unwittingly add to the already tremendous discouragement of our children.

It seems to me that our children are exposed to a sequence of discouraging experiences, both at home and at school. Everybody points out what they did do wrong and what they could do wrong. We deprive the children of the only experience which really can promote growth and development: experience of their own strength. We impress them with their deficiencies, with their smallness, with their limitation; and at the same time try to drive them on to be much more than they can be. If what we want to institute in children is the need to accomplish something, a faith in themselves, and regard for their own strengths; then we have to minimize the mistakes they are making and emphasize all the good things, not which they could do, but which they do do.

A teacher who is defeated by a child who is exceedingly ingenious in defeating her would not think of giving the child credit for the ingenuity and brains which he uses in defeating her. But that's exactly the only thing which might get the child to stop defeating her: If he could get some appreciation for what he is doing instead of being told, "You can't do it to me," when the teacher knows as well as the child that he can. But for every one child who really studies and grows and learns and applies himself, driven by this fear of "you are not good enough, not what you ought to be. You have to try so hard"--for every one of these children who succeeds, there are literally thousands who give up: "I can't be as good as Mom and Teacher want me to be. What's the sense of trying. I can't be as good and important as I want to be. I have to find other ways--and to switch to the useless side."

Most of our juvenile delinquents are the product of a perverted ambition instilled in them by well-meaning parents and teachers telling them how good they ought to be. Only that they preferred to be good in easier ways than by studying and applying themselves. If they smoke, drive hot-rods, indulge in sex, get in conflict with the police, break windows and whatever have you; then they are heroic, then they are important. It's easier and much more gratifying because they really feel important--and, by golly, our fear gives them all the reason to feel important because they defeat us, society collectively, as they defeat their teachers and parents. And they are all over-ambitious, driven by their ideal of how important they ought to be and finding no other outlet except on the useless side, by misbehaving.

And so this mistaken idea of the importance of mistakes leads us to a mistaken concept of ourselves. We become overly impressed by everything that's wrong in us and around us. Because, if I am critical of myself, I naturally am going to be critical of the people around me. If I am

sure that I am no good, I have at least to find that you are worse. That is what we are doing. Anyone who is critical of himself is always critical of others.

And so we have to learn to make peace with ourselves as we are. Not, the way many say, "What are we after all? We are a speck of sand on the beaches of life; we are limited in time and space. We are so small and insignificant. How short is our life, how small and insignificant is our existence. How can we believe in our strength, in our power?"

When you stand before a huge snow-capped mountain, or are in a thunderstorm--most people are inclined to feel weak and awed, confronted with this majesty and power of nature. And very few people draw the only conclusion which in my mind would be correct: The realization that all of this power of the waterfall, this majesty of the mountain, this tremendous impressiveness of the thunderstorm are part of the same life which is in me. Very few people who stand in awe of this expression of nature stand in awe before themselves, admiring this tremendous organization of their body, their glands, their physiology, this tremendous power of their brain. This self-realization of what we are missing because we are only slowly emerging from a traditional power of autocracy where the masses don't count and only the brains and only the emperor and the divine authority know what was good for the people. We haven't freed ourselves yet from the slave mentality of an autocratic past.

How many things would be different in everyone's surroundings if we hadn't lived? How a good word may have encouraged some fellow and did something to him that did it differently and better than he would have otherwise. And through him somebody else was saved. How much we contribute to each other, how powerful we each are--and don't know it. And that is the reason why we can't be satisfied with ourselves and look to elevate ourselves--afraid of the mistakes which would ruin us--and try desperately to gain the superiority over others. So perfection, therefore, is by no means a necessity: It is even impossible.

There are people who are always so afraid of doing wrong because they don't see their value; remain eternal students because only in school one can tell them what is right, and they know how to get good grades. But in life you can't do that. All people who are afraid of making mistakes, who want to by all means to be right, can't function well. But there is only one condition on which you can be sure you are right when you try to do something, to do right. There is one condition alone which would permit you to be relatively sure whether you are right or wrong. That is afterwards. When you do something you never can be sure--you can only see if it is right by how it turns out. Anybody who has to be right can't move much, can't make any decision, because we can never be sure that we are right. To be right is a false premise and it usually leads to the misuse of this right. Have you any idea of the difference between logical right and psychological right? Have you any idea of how many people are torturing their friends and their families because they have to be right--and unfortunately they are? There is nothing worse than the person who always has the right argument. There is nothing worse than a person who always is right morally. And he shows it.

We are dealing in America with a horrible danger to which we have to call attention. Do you know that our American women are becoming a general, universal threat? Merely because they try so hard to be right? Go into any average classroom and look at all those bright, intelligent students--who are girls. And look at all the toughs who don't want to come to school and don't want to study. Look at all these mothers who try so desperately to be good--and their husbands and their children don't have a chance.

This right morally and right logically is very often on offense to human relationships. In order to be right you sacrifice kindness, patience; if you want, tolerance. No, out of this desire for rightness we don't get peace, we don't get cooperation; we merely end up by trying to give the others the idea of how good we are when we can't even fool ourselves. No, to be human does not mean to be right, does not mean to be perfect. To be human means to be useful, to make contributions, not for oneself, but others. To take what there is and make the best out of it. It requires faith in oneself and faith and respect for others. But that has a prerequisite: That we can't

be overly concerned with their shortcomings, because if we are impressed and concerned with their shortcomings, we have no respect, neither for ourselves nor for others.

We have to learn the art, and to realize that we are good enough as we are--because we never will be better, regardless of how much more we may know, how much more skill we may acquire, how much status or money or what-have-you. If we can't make peace with ourselves as we are, we never will be able to make peace with ourselves. And this requires the courage to be imperfect; requires the realization that I am no angel, that I am not superhuman, that I make mistakes, that I have faults; but I am pretty good because I don't have to be better than the others. Which is a tremendous relief. If you accept just being yourself, the devil of vanity, the golden calf of my superiority vanish. If we learn to function, to do our best regardless of what it is; out of the enjoyment of the functioning we can grow just as well, even better than if we would drive ourselves to be perfect--which we can't be.

We have to learn to live with ourselves and the relationship of natural limitations and the full awareness of our own strengths.

oooooooooooooooooooooooooooo



## **Risk Taking is Free**

To laugh is to risk appearing the fool.

To weep is to risk appearing sentimental.

To reach out for another is to risk involvement.

To expose feeling is to risk exposing your true self.

To place your ideas, your dreams before the crowd is  
to risk their loss.

To love is to risk not being loved in return.

To live is to risk dying.

To hope is to risk despair.

To try is to risk failure.

But the risk must be taken, because the greatest hazard  
in life is to risk nothing.

The person who risks nothing, does nothing, has  
nothing and is nothing.

He may avoid suffering and sorrow, but he simply  
cannot learn, feel, change, grow, love, live.

Chained by his certitudes, he is a slave, he has  
forfeited freedom.

ONLY A PERSON WHO RISKS -- IS FREE

Author Unknown

## THROUGH THE PRISM OF OUR NEEDS

Article syndicated by the  
Washington Post Writers Group  
By: Ellen Goodman

"He is not REALLY like that," she said apologetically as her husband left the room.

"Like what?" I asked, wondering which of the many things that had happened that evening she was excusing.

"Well, you know," she said, "cranky."

I thought about that. Cranky. It was typical of the woman that she would choose a gentle, even childish, word for the sort of erratic outbursts of anger which had been her husband's hallmark for the past 15 years.

He was not really like that. This had been her sentence when they were dating, when they were living together, and, now, since they were married.

When he questioned, minutely, the price-tags of her purchases, she would say: "He is really, deep down, very generous." When he disagreed with her politics, veering to the right while she listed to the left, she would cheerily insist that underneath all that he was "basically" liberal.

When he blamed her for the condition of the house, as if he were a lodger, and blamed her for the children's illness, as if her negligence had caused their viruses, she would explain, "He is really very understanding."

Even when he was actually his most vital self, amusing and expansive, full of martinis or enthusiasms or himself, and she disapproved, she would forgive him because he wasn't really like that.

This time, dining with them out of town one brief night, I saw that this was the pattern of their lives together -- a struggle between realities. His real and her really.

I had known the wife since college and the husband from their first date. When they met she was a social worker and he was, it seems, her raw material. Was he the case and she the miracle worker? At times she looked at him that way.

Her husband was erratic and difficult, but he had a streak of humor and zaniness as attractive as Alan Arkin's. Over the years, he had grown crankier and she more determined in her myth-making.

This trip, for the first time, I wondered what it must be like to be a text living with an interpreter. To be not really like that. And what it must be like for her, living with her myth as well as her man.

I know many other people who live with their ideas of each other. Not with a real person but with a really. They doggedly refuse to let the evidence interfere with their opinions. They develop an idea about the other person and spend a lifetime trying to make him or her live up to that idea. A lifetime, too, of disappointments.

As James Taylor sings it:

First you make believe  
I believe the things  
that you make believe  
and I'm bound to let you down.  
Then it's I who have been deceiving  
Purposely misleading  
And all along you believed in me.

But when we describe what the other person is really like, I suppose we often picture what we want. We look through the prism of our need.

I know a man who believes that his love is really a very warm woman. The belief keeps him questing for that warmth. I know a woman who is sure that her mate has hidden strength, because she needs him to have it.

Against all evidence, one man believes that his woman is nurturing because he so wants her to be. After 20 years, another woman is still tapping hidden wells of sensuality in her mate, which he has, she believes, "repressed."

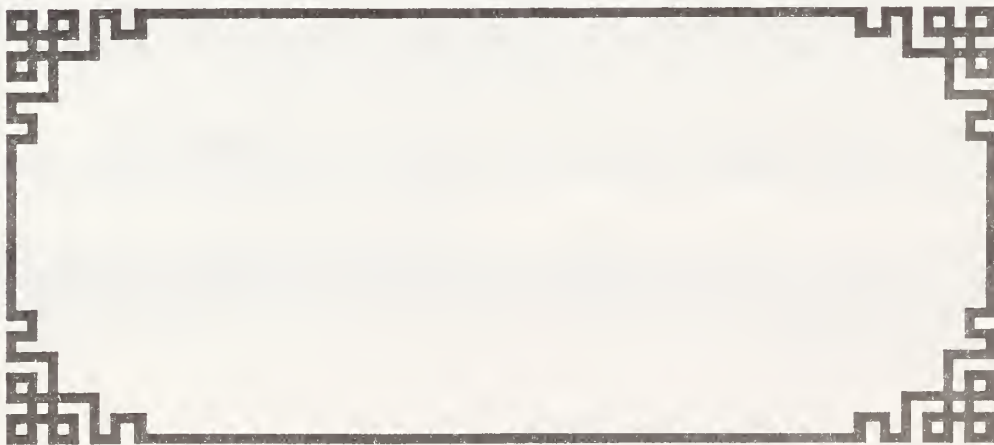
And maybe they are right and maybe they are wrong, and maybe they are each other's social workers. But maybe they are also afraid that if they let go of their illusions, they will not like each other.

We often refuse to see what we might not be able to live with. We choose distortion.

Leaving this couple, I thought about how much human effort can go into maintaining the "really." How much daily energy that might have gone into understanding the reality -- accepting it or rejecting it.

How many of us spend our lives trying to sustain our myths, and how we are "bound to be let down." Because most people are, after all, the way they seem to be.

REALLY.



## PLEASE HEAR WHAT I'M NOT SAYING

author unknown

Don't be fooled by me.  
Don't be fooled by the face I wear.  
For I wear a mask. I wear a thousand masks.  
Masks that I'm afraid to take off.  
And none of them are me.

Pretending is an art that's second nature with me;  
But don't be fooled, for God's sake don't be fooled!  
I give you the impression that I'm secure.  
That all is sunny and unruffled in me.  
Within as well as without.  
That confidence is my name and coolness my game.  
That the water's calm and I'm in command.  
And that I need no one.  
But don't believe me.

My surface may seem smooth, but my surface is my mask.  
My ever-varying and ever-concealing mask.  
Beneath lies no smugness, no complacency.  
Beneath dwells the real me, in confusion, in fear, in aloneness.  
But I hide this.  
I panic at the thought of my weakness and fear being exposed.  
That's why I frantically create a mask to hide behind.  
A nonchalant, sophisticated facade to help me pretend.  
To shield me from the glance that knows.  
But such a glance is precisely my salvation.

That is, if it's followed by acceptance.  
If it's followed by love.  
It's the only thing that can liberate me from myself.  
From my own self-built prison walls.  
From the barriers that I so painstakingly erect.  
It's the only thing that will assure me of what I can't assure myself...  
That I'm really worth something...  
But I don't tell you this, I don't dare...I'm afraid to.  
I'm afraid your glance will not be followed by acceptance and love.  
I'm afraid you'll think less of me, that you'll laugh...  
And your laugh will kill me.

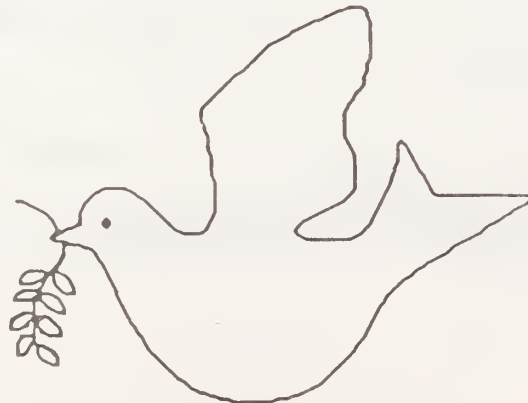
I'm afraid that deep down I'm nothing, that I'm just no good.  
And that you will see this and reject me.  
So, I play my game, my desperate pretending game.  
And my life becomes a front.

I dislike the superficial game I'm playing.  
The superficial, phony game.  
I'd really like to be genuine and spontaneous, and me,  
But you've got to help me.  
You've got to hold out your hand...  
Even when that's the last thing I seem to want or need.  
Only you can wipe away from my eyes the blank stare of the breathing dead...  
Only you can call me into aliveness...

Each time you are kind and gentle and encouraging.  
Each time you try to understand because you really care.  
My heart begins to grow wings...  
Very small wings, very feeble wings, but wings.  
With your sensitivity and sympathy, and your power of understanding.  
You can breathe life into me.  
I want you to know that.  
I want you to know how important you are to me,  
How you can be a creator of the person that is me, if you choose to...

It will not be easy for you.  
A long conviction of worthlessness builds strong walls.  
The nearer you approach me, the blinder I may strike back;  
It's the irrational, but despite what the books say about man,  
I'm irrational!!

I fight against the very thing that I cry out for.  
But I am told that love is stronger than strong walls, and in this lies my hope.  
My only hope.  
Please try to beat down those walls with firm hands.  
But with gentle hands - for a child is very sensitive.  
Who am I, you may wonder?  
I'm someone you know very well...  
For I am every man or woman you meet.



# DEFENSES AS OTHERS SEE US POSSIBLE HIDDEN FEELINGS

Explaining  
Justify  
Intellectualize  
Rationalize  
Minimize  
Theorize  
Analyze  
Switch  
Generalize  
  
Glaring  
Disagree  
Sarcasm  
Threatening  
Attacking  
  
Agreeing  
Flattering  
Joking  
Smiling  
Apologetic  
  
Minimizing  
Evading  
Switching-Shifting  
Silence  
Withdrawing  
Running-Away  
  
Projecting  
Critical  
Rationalizing  
Judgemental  
Justifying  
Attacking  
Excuses

Superior  
Arrogant  
Controlled  
Manipulative

Stubborn  
Defiant  
Hostile  
Angry

People-Pleaser  
Nice Guy  
Wishy-Washy  
Phoney

Aloof  
Indifferent  
Rejecting  
Sullen  
Suspicious

Angry  
Resentful  
Intolerant  
Martyr  
Self-pity

Inadequate  
Angry  
Sad  
Afraid  
Ashamed  
Hurt  
Guilty  
Loneliness

# FEELINGS

abandoned  
accepted  
adamant  
adequate  
adventurous  
affected  
affectionate  
afraid  
agony  
alone  
almighty  
ambivalent  
anger  
animosity  
anxious  
apathetic  
apprehensive  
ashamed  
astounded  
awed

bad  
beautiful  
betrayed  
bewildered  
bitter  
blissful  
bold  
bored  
brave  
brilliant  
burdened

calm capable  
captivated  
caring  
cautious  
challenged  
charmed  
cheated  
cheered  
cheerful  
childish  
clever  
clownish  
cold  
combative  
comfortable

compelled  
competitive  
concerned  
condemned  
confident  
confused  
congenial  
constructive  
contempt  
content  
contrite  
cowardly  
cruel  
crushed

daring  
dazed  
deceitful  
defeated  
defensive  
defiant  
delighted  
desire  
despair  
despondent  
destructive  
determined  
different  
diffident  
diminished  
disappointed  
discontent  
discouraged  
distracted  
distraught  
disturbed  
divided  
dominated  
down  
dubious  
dull

eager  
ecstatic  
elated  
electrified  
embarrassed  
empathy  
empty

enchanted  
encouraged  
energized  
enervated  
enjoy  
envious  
evil  
exasperated  
exhausted  
exhilarated  
exploited

fascinated  
fauning  
fear  
flighty  
flustered  
foolish  
forlorn  
frantic  
free  
frightened  
frustrated  
full  
fury

gay  
glad  
good  
goofy  
graceful  
graceless  
grateful  
greedy  
great  
grief  
groovy  
guilt  
guillable  
gutsy  
gypped

had  
happy  
hate  
heavenly  
helpful  
helpless  
hesitant

high  
homesick  
honored  
hopeful  
hopeless  
horrible  
hostility  
humble  
hurt  
hysterical

ignored  
immortal  
impatient  
important  
impressed  
infatuated  
inferior  
infuriated  
inspired  
intimidated  
intolerant  
irrational  
irritated  
isolated

jealous  
joyful  
jubilant  
jumpy

keen  
kicky  
kind  
knocked-down

laconic  
lazy  
lecherous  
left out  
licentious  
lonely  
longing  
love  
lovely  
loving  
low  
lustful

mad  
manic  
maudlin  
mean  
miserable  
mysterical

natural  
naughty  
nervous  
nice  
numb  
nutty

obligated  
obnoxious  
obsessed  
odd  
opposed  
outraged

overcome  
overjoyed  
overwhelmed

pain  
panicked  
peaceful  
puppy  
persecuted  
petrified  
pinched  
pious  
pity  
playful  
pleasant  
pleased  
poised  
possessive  
precarious  
pressured  
pretty  
prim  
proud  
provoked  
pushed  
put out

quarrelsome

queer

rage  
rapture  
rational  
refreshed  
regret  
rejected  
relaxed  
relieved  
reluctant  
remorse  
resented  
resigned  
respectable  
restless  
revengeful  
reverent  
rewarded  
righteous  
robbed

sad  
sated  
satisfied  
scared  
screwed up  
secure  
selfish  
self-pity  
servile  
settled  
sexy  
shocked  
shy  
sick  
silly  
skeptical  
snappy  
sneaky  
sorrowful  
spiteful  
startled  
stubborn  
stunned  
stupid  
successful  
sucked in  
suffering

superior  
sure  
surprised  
surrender  
suspicious  
sympathy

talkative  
tempted  
tenacious  
tenuous  
tense  
tentative  
terrible  
terrified  
threatened  
thwarted  
tired  
tranquil  
trapped  
troubled

ugly  
uncomfortable  
understood  
uneasy  
unhappy  
unloved  
unmasked  
unnatural  
unsettled  
unsure  
unworthy  
used

violent  
vehement  
vital/vitality  
vulnerable  
vivacious

warm  
weary  
weepy  
witty  
wonderful  
worthy

"you want"

"you wish"  
"you like"



FAMILY ASPECTS  
&  
CHILDREN OF ALCOHOLICS



## THE ALCOHOLIC AND THE FAMILY

Please remember that chemically dependent or drug addict could be substituted for the word alcoholic with no appreciable difference.

Generally, the family is affected by alcoholism to the same extent that the alcoholic has progressed in his illness.

As the alcoholic moves deeper into his addiction, the alibi system is used so effectively that he convinces the family that this is truly the way things are. It has been said that the sign of a successful salesman is that he sells himself on his product first, and then he sells his customers on the product on the basis of his firm conviction. The alcoholic is a super-salesman. As stated earlier, he truly believes his alibis. And, being such a good salesman, he sets out to convince his family. The tragedy is that he is so effective. The family accepts the alibis and believes them just as the alcoholic does.

As the alcoholic denies his problem, the family may join him in his denial, truly believing a problem doesn't exist. As he rationalizes his need to drink, the family comes to believe that, given the conditions of his life, anyone would drink. And, as he projects blame for his drinking onto others, the family tends to believe that others (including themselves) are responsible for his drinking.

In addition to falling in with an alcoholic's alibi system, family members are usually wound up in their own systems of denial, rationalization, and projection. The family can "enable" the alcoholic in such ways as calling in "sick" for him when he's suffering from a hangover the morning after. The family can be extremely protective, letting no one outside the immediate family know about the alcoholism, shielding the alcoholic (and themselves) from exposure and embarrassment. Or they can "walk on eggshells" around the alcoholic, treating him with undue care and respect to protect themselves from the alcoholic's recrimination. Some family members may avoid the issue altogether--be out when the alcoholic is at home, and refuse to speak about the problem with others in the family. It's like having an elephant in the middle of the room, and while everyone is privately aware of its presence, no one talks to anyone about it.

When the family accepts the alcoholic's alibis, each member begins to define a different position for himself within the family. Each one genuinely believes that he is, in some way, at fault, and he tries to change his behavior to remedy the situation. Each is certain that if he does things better (or different, or more diligently), the alcoholic will respond and stop drinking. This position indicates that the family member is feeling guilty--that he believes he is at fault. This is part of the "line" that the super-salesman (the alcoholic) has sold him; and guilt is one of the most common feelings surfacing in family members.

Other feelings, equally common, are fear and anger.

Family members are fearful for a variety of reasons--sometimes because of physical abuse, sometimes verbal abuse, sometimes both. They are fearful of what he will say or do in front of others which might cause them embarrassment. They are afraid that the alcoholic will hurt himself during his drinking, to the point that he may end up dead. And, at times, they may be afraid for their own lives.

They are angry for having been treated so poorly, and about the promises the alcoholic has failed to keep. They don't like his arriving home late for meals, or his missing school functions. They are angry because he is not with the family for holidays and other family functions and events.

And the guilt is felt because they truly believe they've done something wrong. The alcoholic's wife feels sure that, if she quit nagging and had meals ready on time, the alcoholic would respond. In the case of the female alcoholic, her husband searches for ways to be more cooperative within the family structure, sometimes taking over some of her duties. Children believe that keeping their rooms neater, getting better grades in school, being more respectful to their parents, or doing their assigned household tasks better would change the alcoholic.

And confusion reigns.

IT IS SIMPLY NOT TRUE THAT THE FAMILY IS TO BLAME FOR THE ALCOHOLISM

## FAMILY DISEASE

To understand how the family disease evolves we must first understand the family dynamics of any illness. Basically this begins with realizing we nurture the ill person (identified client). However, the dynamics become prominent when the illness we are dealing with also includes "loss." Chemical dependency is such an illness which encompasses a great deal of loss.

To understand the process we are going to look at the reaction of a family to a crisis of terminal disease. The family, as does the patient, goes through stages adapting to the loss.

I. **DENIAL** — "It can't happen to me." "I won't crash, someone else will." The family also goes through this stage; for them "It won't happen to my family member."

II. **ANGER** — (Displaced Anger)  
For Patient — "Why me?"  
for Family — "Why my family member?"

Parents become angry when the adolescent is using and is caught — at this point it interferes with their life and they become angry but verbalize it as "frustration — just a little anger."

III. **BARGAINING** — This is a hopeful time, "If...then...." "If I am good then it will change."  
For Patient — "If I cut down my use then teachers/family won't hassle me."  
For Family — "If I make a stricter curfew, then he will not use, he will get better."

And if there are two parents they will emotionally be in different spots thus displaying inconsistencies.

IV. **DEPRESSION** — Adjusting to loss.  
For Patient — change in behavior, grieving the loss to recreationally used chemicals.  
For Family — parents grieving for the child. Losing their child, i.e., not a little child anymore, loss of innocence, losing their parenthood of that child.

V. **ACCEPTANCE**— Peaceful resolution to the illness, obtain relief and look to new things.

## FAMILY SYSTEM PERSPECTIVE

- I. Families operate as a system:
  - A. Roles, relationships, communication styles and power distribution balances the system.
  - B. Chemical dependency imbalances the system; families react/adjust in a mode which will rebalance the system.
  - C. A primary family goal is homeostasis.
  - D. No family system is healthy all the time.
  - E. In healthy family systems, both system and individual needs are met; the system is fluid, open and predictable.
- II. Survival roles within a chemically dependent family system include:
  - A. **Chief Enabler:** assumes primary responsibility for sheltering and shielding the chemically dependent from harmful consequences; roles vary with the stage of the illness process and include controller, waverer, and sufferer.
  - B. **Family Hero:** assumes responsibility of being family's self-worth and family counselor; internal emotions in direct conflict with external behaviors; emotions include low self-worth, fear and loneliness; may develop relationship problems at later age if person is a child.
  - C. **Family Scapegoat:** primary function is to divert attention away from family pain by inappropriate, usually anti-social behavior; internal emotions are anger, resentment and fear. May be chemically dependent child, especially if a parent is chemically dependent.
  - D. **Lost Child/Adult:** primary goal is to escape by emotional and/or physical disconnection; family tends to appreciate and reinforce child for having "no" needs; loneliness, unworthiness and fear are extreme.
  - E. **Family Mascot:** primary function is to divert attention away from family pain by the use of humor; mascot feels unloved and worthless.
  - F. Roles can change with time, the leaving of/addition of family members.
  - G. Roles can be permanent for individuals; new generations of chemical dependency tend to be created.
  - H. Extended family members can develop survival roles also.

## FAMILY ILLNESS PROCESS

- I. Stage 1: Denial (Incidents of inappropriate chemical usage begin, but are sporadic.)
  - A. Family adjusts/reacts:
    1. Family is embarrassed/humiliated, especially parents.
    2. Family discusses situation; promises, excuses and apologies result.
    3. During "normal" periods, family sees themselves as exaggerating the problem and feels disloyal.
    4. Family relations show strains; perfect family illusion is created.
    5. Family, especially parents, seek advice from friends and relatives.
    6. Early control attempts may be tried.
  - B. Main priority is family reputation.
  - C. Denial and minimization are prominent; potential dependency is absolutely denied.
- II. Stage 2: Elimination (Inappropriate chemical usage increases but is not constant.)
  - A. Family adjusts/reacts:
    1. Family experiences and facilitates social isolation.
    2. Chemical usage discussions are avoided by friends and relatives.
    3. Family operates on principles of self-sufficiency and "addict" stereotypes.
    4. Family loses perspective on system health.
    5. Adolescent chemically related behavior becomes focus of family anxiety.
    6. Family covers up to school, courts, friends, relatives, children, etc.
    7. Resentment builds within family system (parents vs. the chemically dependent person; children vs. parents, etc.).
    8. Family, especially parents, explore frantically the reasons for chemical use.
    9. Parents feel like failures; self-worth decreases.
    10. During "normal" periods, the chemically dependent person may treat family royally; results in guilt and prevents adjustment.
    11. Trial and error control methods initiated.
    12. Attempts made to maintain the illusion of roles; increase confusion.
  - B. Family feels self-pity, inadequate and right; whole family feels the effects.
  - C. Goal of this stage is to isolate, control and eliminate problem.

- III. Stage 3: Disorganization (Inappropriate chemically related behavior becomes relatively permanent situation.)
- A. Family adjusts/reacts:
    - 1. "Effective" control techniques primarily utilized.
    - 2. Children confused; may develop school/social/adjustment problems.
    - 3. Violence occurs; involves whole family.
    - 4. Police/medical/social assistance needed.
    - 5. Family feels along, helpless, trapped and immobilized.
    - 6. Survival roles developed.
  - B. Predominant feelings are fear and confusion; all is chaos.
  - C. Family may be unable to take constructive action.
- IV. Stage 4: Reorganization Around the Problem (Preceded by major crisis)
- A. Family adjust/reacts:
    - 1. Chemically dependent person (C.D.) is cast out of family role and responsibilities.
    - 2. C.D. is either ignored or treated as recalcitrant child.
    - 3. Battle for children intensifies.
    - 4. C.D. feels ignored; reacts with withdrawal or aggression.
    - 5. Health, legal and possibly financial fears increase.
    - 6. May try A.A., detox, treatment, etc.; hope is brief and may be utilized as punishment.
    - 7. Family may get information on chemical dependency; may disregard or utilize as "magic."
    - 8. Family admits problem and becomes less isolated.
  - B. Non-C.D. family members stabilize somewhat and regain "surface" power.
  - C. Fear and problems may intensify; family will not take constructive action.
- V. Stage 5: Efforts to Escape the Problem (Preceded by crisis.)
- A. Family adjusts/reacts:
    - 1. Temporary physical separations (desertion, expulsion, etc.)
    - 2. C.D. manipulates by stressing helplessness.
    - 3. Family torn between leaving and staying with C.D.
    - 4. Outside pressure and advice is conflicting; family utilizes to make no decision.
    - 5. Family may become emotionally isolated from C.D. but still cannot break bonds or take constructive action.

- B. Family can remain in “decision-making, procrastination” state forever.
  - C. Primary goal is to save “sober” part of family but not at the cost of action.
- VI. Reorganization of Part of the Family (Family physically separates)
- A. Family adjusts/reacts :
    - 1. Usually C.D. only leaves, but not always; C.D. may leave with some family members.
    - 2. Family faces problems of non-nuclear family system.
    - 3. Family may remain emotionally connected; may feel guilt about desertion; may recall only good times.
    - 4. C.D. may periodically return; may still financially support, have family violence, etc.
    - 5. Family members probably will remain in their survival roles.
  - B. Family separates but probably does not develop a health system.
  - C. A new dependency or problem may develop in order to accommodate system needs.
- VII. Stage 7: Recovery and Reorganization of the Whole Family (C.D. and family initiate a recovery process.)
- A. Family adjusts/reacts:
    - 1. Family may experience initial “honeymoon” period.
    - 2. C.D. must be allowed to resume roles and responsibilities.
    - 3. Family must adjust to “sober” personality and whole recovering people.
    - 4. Trust and forgiveness must grow; fear of relapse must be accepted.
    - 5. Family may be overly demanding of C.D.
    - 6. Family may resent recovery emphasis.
  - B. Entire family system needs help and needs to recover.

## BIBLIOGRAPHY

- Jackson, Joan. “The Adjustment of the Family to the Crisis of Alcoholism.” *Quarterly Journal of Studies on Alcohol*, Vol. 15 (Dec., 1954).
- Lewis-Steere, Cindy. *But I Didn't Make Any Noise About It*. CompCare Publications, 1980.
- Satir, Virginia. *Peoplemaking*. Science and Behavior Books, Inc., 1972.
- Snyder, Anne. *Kids and Drinking*. CompCare Publications, 1977.
- Wegscheider, Don. *If Only My Family Understood Me ...*. CompCare Publications, 1979.

## CHEMICAL DEPENDENCY, A FAMILY DISEASE

- 1) Do you lose sleep because of the problem user?
- 2) Are more of your thoughts revolving around the problem user or problems that arise because of him or her?
- 3) Do you exact promises about the drug use which are not kept?
- 4) Do you make threats or decisions and not follow through with them?
- 5) Has your attitude changed toward the problem user? (no longer trust him or her)
- 6) Do you search the problem user's room and/or personal belongings for evidence of drugs or drug use?
- 7) Do you think that everything would be okay if only the problem user would stop or control the using?
- 8) Do you feel alone — fearful — anxious — angry and frustrated most of the time. Are you beginning to dislike yourself and wonder about your sanity?
- 9) Do you find your moods fluctuating wildly as a direct result of the problem user's moods and actions?
- 10) Do you feel responsible and guilty about the using problem?
- 11) Do you try to conceal the problem from others (school, relatives, police)?
- 12) Do you find yourself denying the drug problem, despite evidence that there is a drug problem?
- 13) Have you withdrawn from outside activities and friends so you can watch the problem user more closely?
- 14) Have you experienced embarrassment or shame over the drug problem?
- 15) Do you feel forced to try to exert tighter control over the problem user with less and less success, and are the problems increasing?
- 16) Do you or have you argued with other family members over the problem user's drug use and/or behavior?
- 17) Have you noticed physical symptoms in yourself, such as nausea — a "knot" in the stomach — ulcers — shakiness — headaches — sweating palms — bitten fingernails?
- 18) Do you feel discouraged that nothing you can do will move the problem user?

## FAMILY STRUCTURES

### I. FAMILY

That emotional field that goes back two generations (child, parents, grandparents, including siblings, aunts, uncles, etc.).

### II. FAMILY SYSTEMS

A way to view things as they happen to the family unit, the unit being comprised of members who relate to each other. The unit is a system which maintains a balance.

### III. FAMILIAL HOMEOSTASIS

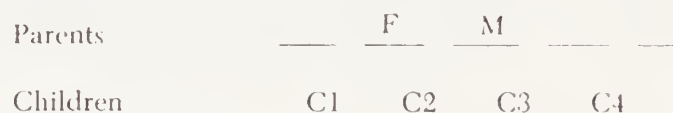
A) **Functional** — there is a cooperative effort among the family to maintain a balance like that seen in a mobile. Roles, relationships, communication styles and power are all normalized to maintain the balance.

B) **Dysfunctional** — an unequal distribution of roles, relationships, communication styles, and power upsetting the balance with the family reacting by adjusting their roles. Unhealthy subsystems and coalitions will develop in order to balance out the needs of the family members.

For example: Mother waits up for Karen to come home; father goes to bed. Balance is maintained but is dysfunctional. Karen also provides mother an out to avoid father, and she provides a spark to an otherwise boring marriage. Parents cope in the most effortless way, or they blame each other, and themselves. Attempts to make things peaceful.

### IV. BOUNDARIES OF FAMILY STRUCTURES

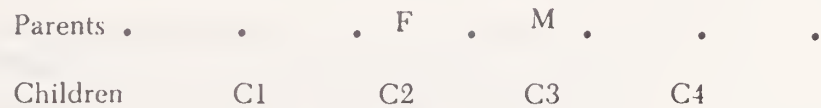
A) Clear Boundaries (Ideal Family)



- 1) Hierarchy is clear
- 2) Know where each other stands
- 3) Equal distribution
- 4) Access to each other
- 5) Able to communicate
- 6) Boundaries are permeable

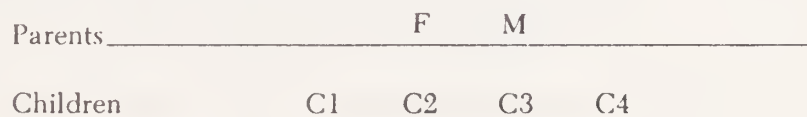
## FAMILY STRUCTURES

### B) Diffused Boundaries (Enmeshed Family)



- 1) Live solely for each other
- 2) Cut off outside systems due to engrossment with family
- 3) Minor crisis for one member becomes crisis for whole family
- 4) Family members move around and become unequally distributed; too permeable; child and parent may switch roles.

### C) Rigid Boundaries (Disengaged Family)



- 1) Has isolated subsystem
- 2) Minimal communication
- 3) Apathetic
- 4) Crises have to reach major proportions before they will act

## V. FAMILY WITH CHEMICALLY DEPENDENT ADOLESCENT

### A) Characteristics

- 1) Rigid
- 2) Diffused boundaries
- 3) Coalitions
- 4) Enmeshed family
- 5) A lot of secrets
- 6) Enabling

### B) Mutual Problems

- 1) Ignorance of chemical dependency — intellectual deficit; parents don't know what chemical dependency is. Adolescents usually only know their subjective experiences (not objective knowledge) and assumes their perceptions are the correct ones.
- 2) Denial — emotional denial; unaware of the process of becoming chemically dependent and compartmentalize the various drugs, i.e., "He's only drinking."

## FAMILY STRUCTURES

- 3) Failure to give and accept responsibility; either too much too soon, or too little too late. May hold the child completely from responsibility and perhaps look for "the" cause of the abuse/dependency (projection) by blaming schools, peers, etc.
- 4) Anger and hate versus love and affection — child uses reaction formation to avoid threatening anger or feelings of hate, thus they "love." Parents are just as angry but anger comes out saying "I love you." Both states exist and need not be exclusive or "versus" each other.
- 5) Ambivalence — having two opposing feelings at the same time, i.e., "I want to quit using but I don't want to." For parents, "I don't want you to use, but I want you a child again — can't let go."
- 6) Lack of honesty — not honest about their dependency/use. Lack of honesty in communication. Parents need to be more honest and public about the problems to allow for support and a path for acceptance; i.e., grandparents or other close people.
- 7) Role model of drug use — is there a parental abuse of chemicals?

## VI. FAMILY WITHOUT OR WITH LITTLE CHEMICAL USE

- 1) Tend to perceive more love from both parents, especially with father -- father is there and accessible — in treatment we foster love expressions, i.e., "Tell the child you love him/her." Help to enable these love expressions.
- 2) Children are more assertive -- open, honest sharing of differences and these differences are heard and respected; in treatment we foster these assertive expressions.
- 3) Parents/child are compatible. Less approval of drug use by parents and peers; in treatment we foster disconnecting from drug-using peer group. They are good friends, but unhealthy ones. Identify internalized values.
- 4) Problem-solving is spontaneous and efficient; in treatment we teach solutions.
- 5) Family functions democratically but with clear authority -- mother and father are unified.
- 6) Have fun together and structure fun together.
- 7) Sense of family tradition -- associate parent/child experiences and feelings.
- 8) Parents "giving in" in child-rearing: firm but flexible.

## FAMILY STRUCTURES

### THE FAMILY MOBILE

THE FAMILY IS AN ORGANISM — not unlike a mobile:

- \* its parts are interdependent
- \* it works together for:
  - peace & harmony
  - destruction
  - survival
- \* each member adapts a behavior that causes the least amount of stress

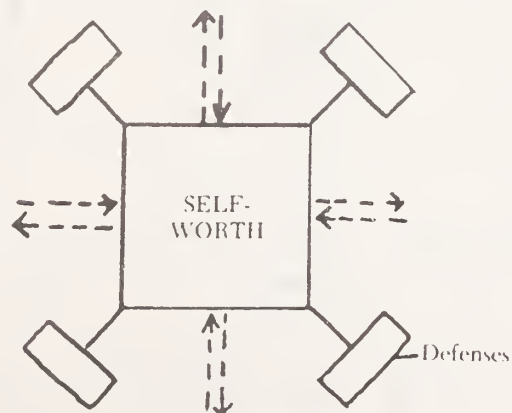
A MOBILE:

- \* A hanging art form made up of shapes, rods and strings
- \* The beauty of a mobile is in its **balance** and movement
- \* The mobile responds to changing circumstances (wind, push of a hand) but always maintains balance.
- \* The whole of the system moves interdependently to maintain equilibrium.
- \* Each part is important to the balance of the whole.

A HEALTHY FAMILY:

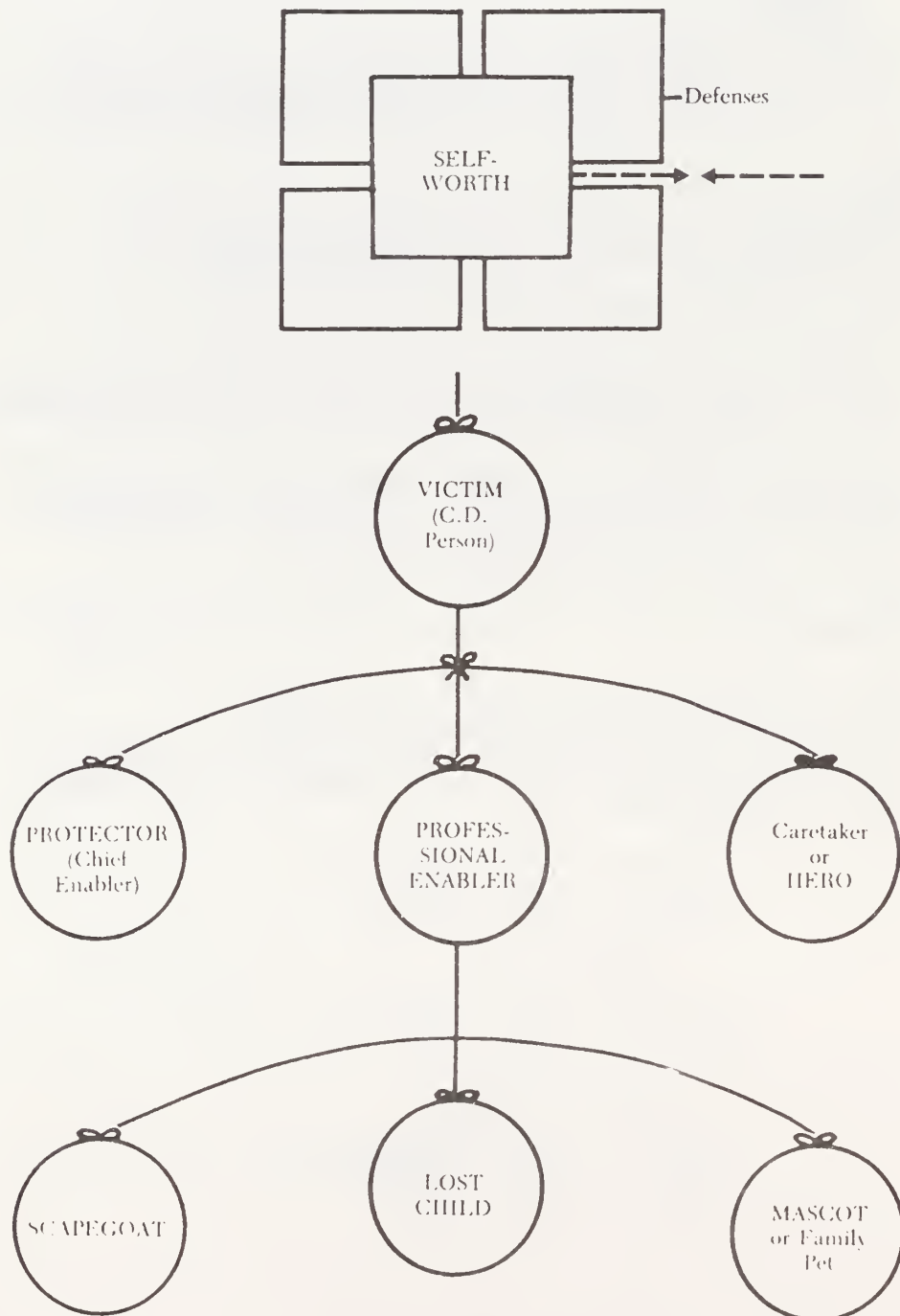
Each member can move freely without upsetting balance.

Each member has defenses for protection but has feelings which can be shared where trust is maintained.



## A CHEMICALLY DEPENDENT OR DYSFUNCTIONAL FAMILY

Develops exaggerated defenses which protect them from pain and adapts a set of behaviors which cause the least amount of personal stress.



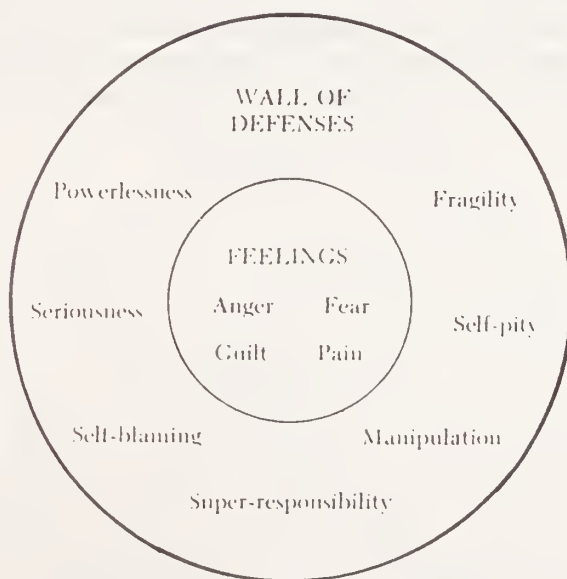
## THE VICTIM



## THE CHIEF ENABLER

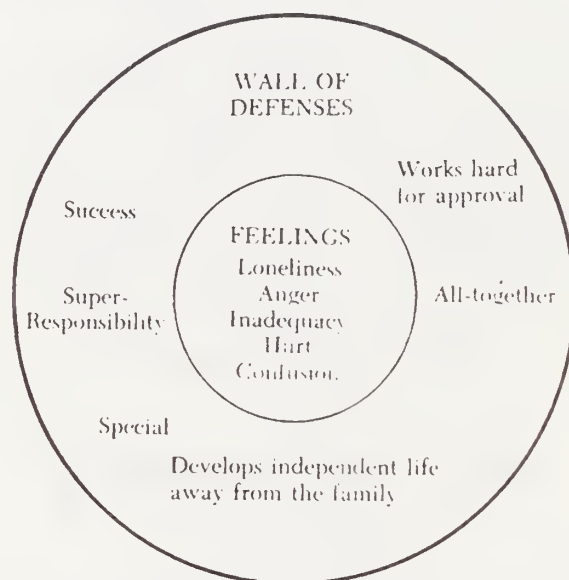
(Protector)

The role of the enabler is to provide responsibility in the family. Often the spouse or parent closest to the Victim (C.D.) assumes this position. The worse the illness, the more the involvement of the protector.



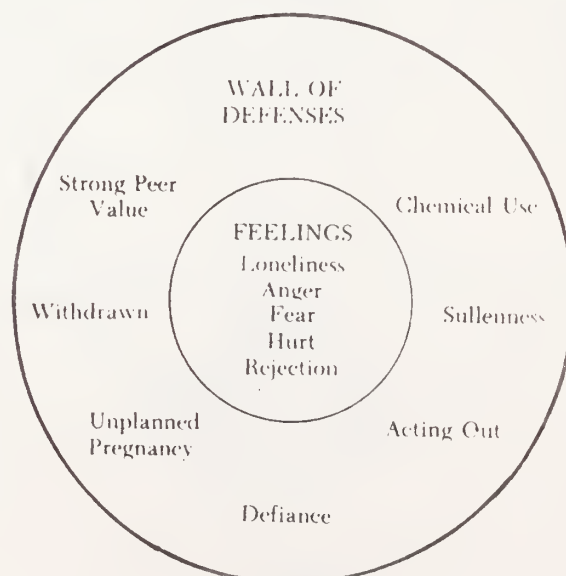
## THE CARETAKER OR HERO

The role of the hero is to provide self-worth for the family. The hero is often the oldest child or "breadwinner" parent; can usually see and hear more of what is really happening; tries to make things better.



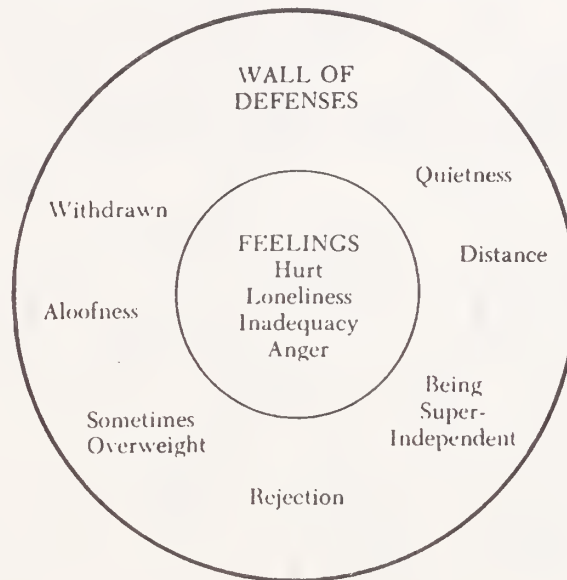
## SCAPEGOAT OR PROBLEM CHILD

The role of the scapegoat is to provide distraction and focus to the family. The scapegoat draws attention within the family, but goes outside for feelings of belonging and worth. He or she may be chemically dependent; may get attention through destructive means.



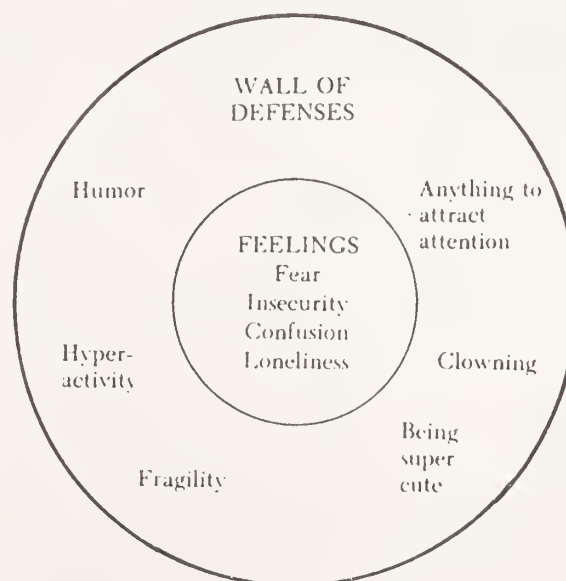
## THE LOST CHILD

The role of the lost child is to offer relief (the one child the family doesn't have to worry about). This child doesn't make close connections in the family; spends much time being alone; is not noticed — either positively or negatively.

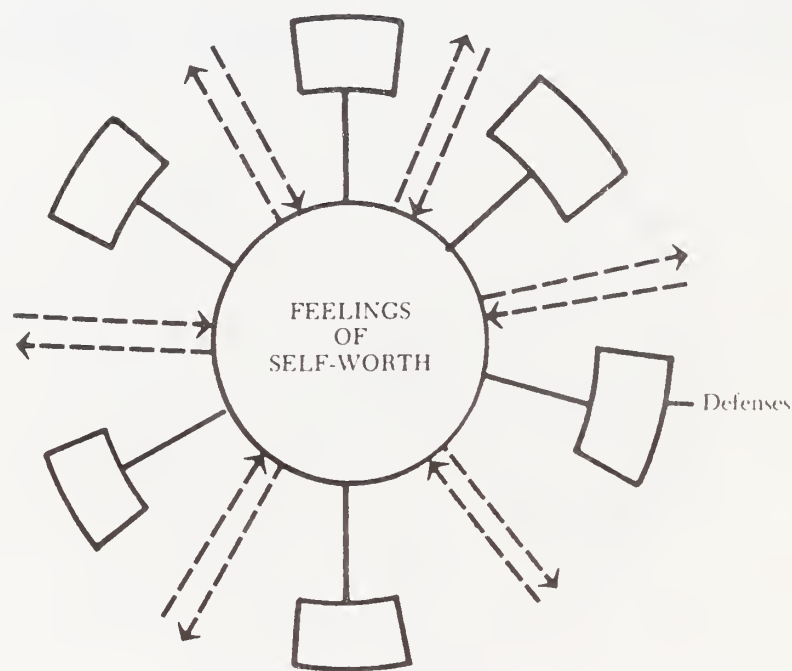


## THE MASCOT OR FAMILY PET

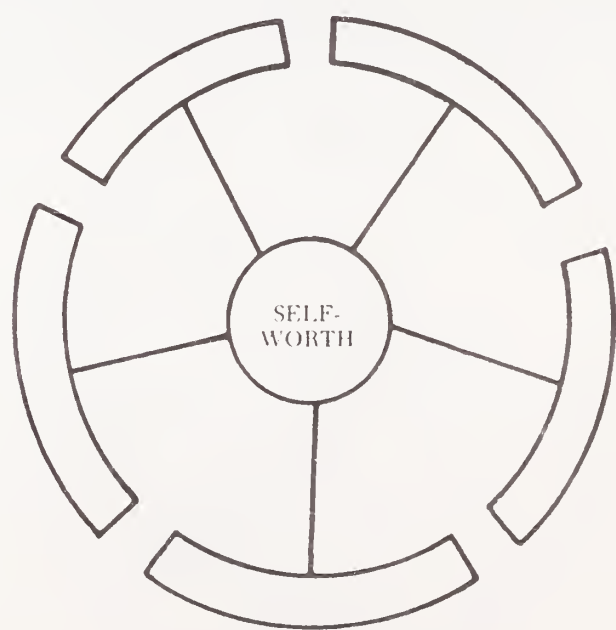
The role of the mascot is to provide fun and humor. The mascot is not taken seriously, is often cute, fun to be around, charming and humorous.



HEALTHY PERSON



DYSFUNCTIONAL PERSON



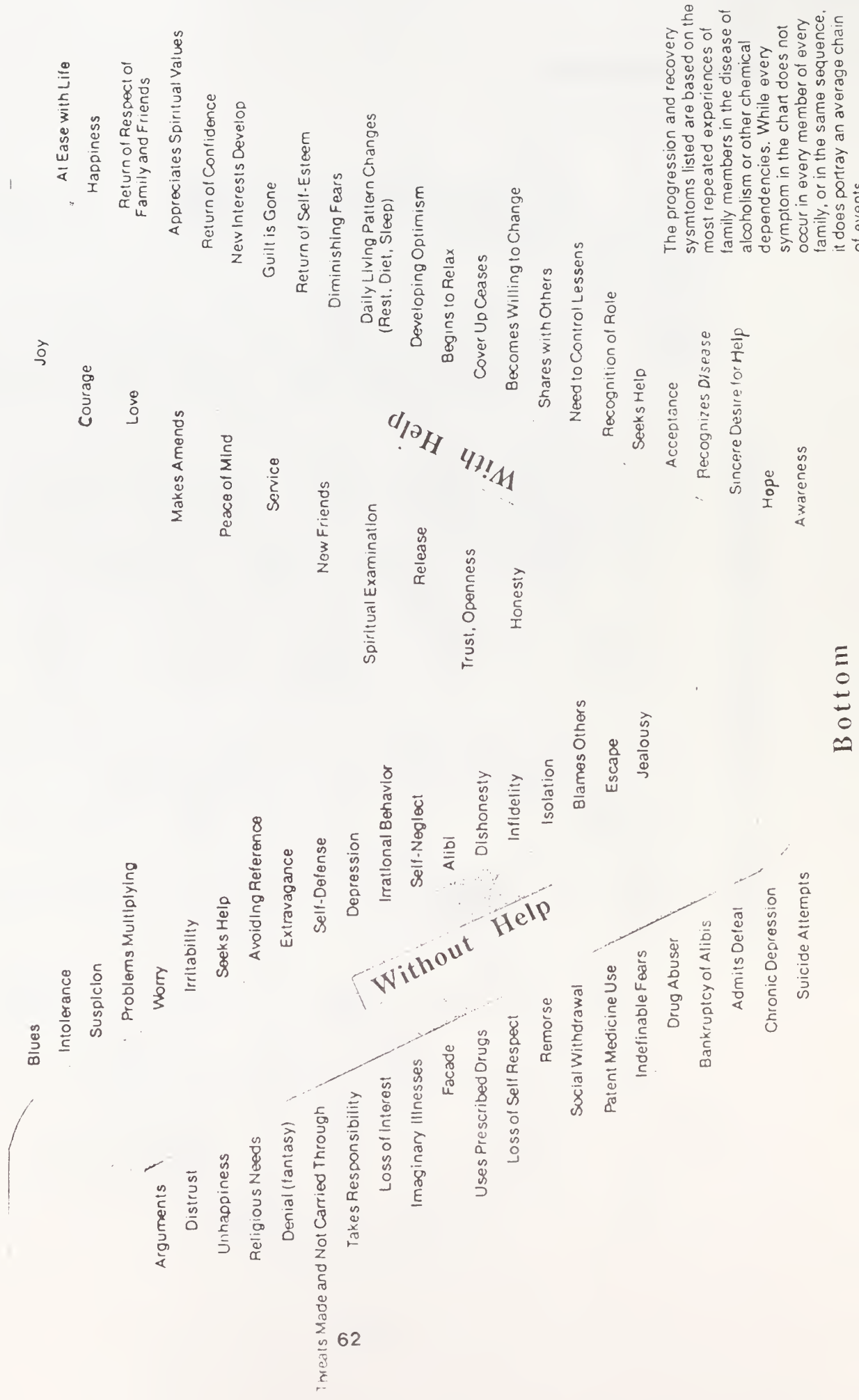
## FAMILY ILLNESS IN CHILDREN

Designed by  
Linda Miv

Information taken from:  
"The Family Trap" by Sharon Wegscheider,  
Johnson Institute, 1976

	Visible Qualities	Inner Feelings	Represents to Family	Characteristics	Possible Future Characteristics	
					Without help	With help
Family Hero	Visible success  Does what's right	Inadequate	Self-worth  (Family can be proud)	High achiever  Grades Friends Sports	Workaholic Never wrong responsible for everything Marry dependent	Accept failure Responsible for self, not all Good executives
Scapegoat	Hostility Defiance Anger	Hurt Guilt	Takes focus off the Alcoholic	Negative attention Won't compete with "family hero"	Unplanned pregnancy Trouble maker in school & later in office Prison	Accept responsibility Good counselors Courage Ability to see reality
Lost Child	Withdrawn Loner	Loneliness Unimportant	Relief (One child not to worry about)	"Invisible" Quiet No friends Follower Trouble making decisions	Little zest for life Sexual identity problems Promiscuous or stays alone Often dies at early age	Independent Talented Creative Imaginative Self-actualized
Mascot	Fragile Immature Needs protection	Fear	Fun & humor (Comic relief)	Hyperactive Learning disabilities Short attention span	Ulcers, can't handle stress Compulsive clown Marry "hero" for care Remains immature	Take care of self No longer clown Fun to be with Good sense of humor

# The Progression and Recovery of the Family in the Disease of Alcoholism



## PERCEPTIONS OF ADULT CHILDREN OF ALCOHOLICS

1. Adult children of alcoholics guess at what normal behavior is.
2. Adult children of alcoholics have difficulty following a project through from beginning to end.
3. Adult children of alcoholics lie when it would be just as easy to tell the truth.
4. Adult children of alcoholics judge themselves without mercy.
5. Adult children of alcoholics have difficulty having fun.
6. Adult children of alcoholics take themselves very seriously.
7. Adult children of alcoholics have difficulty with intimate relationships.
8. Adult children of alcoholics overreact to changes over which they have no control
9. Adult children of alcoholics constantly seek approval and affirmation.
10. Adult children of alcoholics usually feel that they are different from other people.
11. Adult children of alcoholics are super responsible or super irresponsible.
12. Adult children of alcoholics are extremely loyal even in the face of evidence that the loyalty is undeserved.
13. Adult children of alcoholics are impulsive. They tend to lock themselves into a course of action without giving serious consideration to alternative behaviors or possible consequences. This impulsivity leads to confusion, self-loathing, and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess.

## CHILDREN'S ROLES CARRIED INTO THE CLASSROOM

### The Chemically Dependent Youth

- DO:**
1. Set rules (limits). Follow through with consequences when broken.
  2. If you suspect unusual behavior, keep data on school work, attitudes (spacy, mood swings, etc.)
  3. Get support from the other teachers. Ask others who have the child in class. Compare notes.
  4. Set contracts with child which he signs. Use as data if broken.
  5. Call in school counselor. Share concerns and data.
  6. Have parent conference—intervention?

\*Remember—inside = self-hatred = projected out.

- DON'T:**
1. Don't accept blame from child or feel sorry for him.
  2. Don't make special exceptions for child, such as breaking a rule.
  3. Don't let him be irresponsible, such as unfinished work.
  4. Don't argue with him, explain yourself, justify, defend.

#### DEFINITION: HERO

Always volunteering, responsible, compulsion to always be on top, insatiable need for your attention and approval, leaders of class, parental with other children, needing to help others, bossy, disappointment at losing (depressed and down on themselves), superior when winning, obnoxious, often called "teacher's pet" by others.

- DO:**
1. Give attention at times child is not achieving.
  2. Validate personhood. Separate person and his behavior.
  3. Let child know it's okay to make a mistake.

- DON'T:**
1. Let them monopolize conversation, always be first.
  2. Don't validate his/her worth by achievements.

\*Remember—inadequacy, driving feelings.

#### DEFINITION: SCAPEGOAT

Blames, makes peer alliances, acts out, irritating, rigid defiance, irresponsible, teacher puts in hall a lot for disrupting class, sent to principal's office often for breaking rules (i.e., running in hall), talks back to teacher, hardly ever gets work done, teacher feels at end of rope, (angry, frustrated, "I don't know what to do with that child!" "I've tried everything!").

- DO:**
1. Let child know behavior is inappropriate.
  2. Validate his/her taking responsibility for anything.
  3. See that he/she is a hurt child, don't get hooked by the anger, don't defend.
  4. Set limits. Give clear explanations of child's responsibilities—clear choices and consequences.
  5. Help child understand that his behavior is his responsibility—he is in control, use key reminder phrase (i.e., who's in control right now?).
  6. Consistently follow through with consequences.

- DON'T:**
1. Don't feel sorry for the child.
  2. Don't treat child special or give him your power.
  3. Don't agree with child's complaints.
  4. Don't take child's behavior personally.

\*Remember—hurt and guilt under defiance.

**DEFINITION: LOST CHILD**

Can't remember his/her name, wall flower, quiet, never a behavior problem; few, if any friends, often creative—art work or something alone, often low verbal and written skills, either left to themselves or teased (i.e., about never getting involved—"chicken," fat, etc.).

- DO:**
1. Take inventory. Whose name can't you remember; who don't you know?
  2. Try some contact on a one-to-one. Find out who he/she is!
  3. Point out and encourage child's strengths, talents, be aware of creativity.
  4. Try to pick up on interest and often they will talk.
  5. Use touch slowly.
  6. Help child to build a relationship. There will usually be one child they are drawn to.
  7. Encourage working in small groups (two's, three's) to build trust and confidence.

- DON'T:**
1. Don't let this child get off hook by silence—wait until he/she answers.
  2. Don't let others take care of this child (i.e., answer or talk for).

\*Remember—unimportance, primary feeling.

## FAMILY STRUCTURES

### DEFINITION: MASCOT

Funny or distracting, gets class attention, real clown (hiding, making faces, pulling chair out from under someone else, sticking chalk in erasers).

- DO:**
1. It is okay to get angry at mascot's behavior.
  2. Try giving him a job in class with some importance and value and responsibility.
  3. Hold mascot accountable.
  4. Encourage responsible behavior.
  5. Encourage appropriate sense of humor.
  6. Insist on eye contact.

- DON'T:**
1. Laugh at silly behavior.
  2. Laugh with mascot. He won't take you seriously.

\*Remember—underlying fear.

## SUMMARY

1. Understand children's roles as survival mechanisms.
2. Don't take it personally. It's their trip.
3. Don't try to change them; that is only a possibility. Be aware of this, accept it, and give feedback.
4. Teachers aren't fixers. You're not responsible for getting them straightened out.
5. Don't carry their pain.
6. You can help the child, family or counselor/principal see a clearer picture.
7. Anger, frustration, judgment, intolerance are all hooks and don't help children.

(Some of this material is based on the "survival roles" described by Sharon Wegscheider in her publication, *The Family Trap*, Sharon Wegscheider, 1976.)

ENABLING  
&  
INTERVENTION



## PROFESSIONAL ENABLING

Roadblocks to successfully impacting drug use, abuse and dependency.

### 1. AVOIDANCE

- Role Responsibility
- Separation

### 2. ATTITUDES

- "Alcohol Is The O.K. Drug"
- "Good Vs. Bad" Issue
- "Do It For Me"
- "I Have The Way"
- "Ain't It A Shame"

### 3. NARROW EXPERTISE

- Statistics
- Pharmacology
- The Users

### 4. FEAR

- No Talk Rule
- loyalty
- image
- support
- Won't Confront
- certain professions off limits
- labeling

### 5. PROFESSIONAL INCONSISTENCIES

- Harmfully dependent peers
- No example/role model
- Helper not helpee

### 6. USE OF OUTSIDE EXPERTS

- Allowing others to take on the responsibility

### 7. WRONG TARGET GROUP

- Staff, parents, community vs. kids

# SYSTEMS ILLNESS AS APPLIED TO SCHOOLS

PROFESSIONAL ENABLING  
WHAT THEY MIGHT SAY:

CHARACTERISTICS

REPRESENTS TO  
THE SYSTEM

INNER  
FEELINGS

VISIBLE  
QUALITIES

ROLE

CHIEF ENABLER (i.e. teacher or friend)	Super Responsible Optimistic	Anger and Guilt Inadequate	Hope (Everything will be alright)	A Fixer Martyr) Bargains alot Provokes guilt	To Student: "Promise me you won't do it again, o.k.? Stay off the stuff for me!"
HERO (i.e. counselor)	Visible success Does what is right	Anger Inadequate	Self worth (system can be proud of efforts)	High Achiever Well liked	To Colleagues: "What we need is a drug program that teaches them drugs are bad!"
SCAPEGOAT (i.e. angry teacher)	Hostile Defiant Angry	Hurt Guilt	Diversion (takes focus off the problem)	Negative Attention Subversive	To Colleagues: "Those punks don't deserve our help. We should help the kids who do well in school!"
LOST CHILD	Withdrawn Loner	Fearful Unimportant	Relief (problem's not that bad)	Invisible Quiet	To Colleagues: "That's not my job. I'll just teach. that's enough as far as I'm concerned."
MASCOT	Immature Avoids Conflict	Fear	Fun and Humor (comic relief)	Evasive	To Colleagues: "What's the big deal. I used to drink beer in high school and see what a great guy I am."

## THE DIAGNOSIS

It becomes important for one to realize that referral of a student for diagnosis is a serious consideration. The referring person needs to understand the implications of diagnosis and subsequent choices of treatment, especially in the area of chemical dependency. Due to the massive amount of denial utilized by the chemically dependent person, treatment for them can and may need to be of a coercive nature. Thus the referral becomes vitally important. An improper or misdiagnosis can lead to improper treatment, which can be damaging, much in the same way inappropriate medical diagnosis and treatment could be damaging. Labeling the student can also cause serious esteem issues as well as attitudinal biases by others around him.

It is for these reasons that an assessment professional be used for diagnosis. This will allow for the treatment of choice to be cautiously decided. Therefore, the school person should be able and willing to accept his/her limitations.

It is absolutely necessary for the school person to refer on the basis of inappropriate behavior for the school setting, and for this reason only. Thus, a pre-screening at the school becomes quite valuable. This allows for: 1) appropriate use of community agencies/professionals; 2) provides important information which can be used by the professional in assessment and choice of treatment; and 3) avoids referring the healthy student.

## FAMILY ENABLING PROCESS

### I. Enabling

#### A) What is Enabling?

Assists in removing the harmful consequences, minimizing the problem behavior.

#### B) The Enabler —

Someone who wants to “fix” someone who has a problem with drinking. The enabler works very hard at holding him up and keeping him looking good.

### II. Three Stages of Enabling

#### A) Stage 1 — Denial

The enabler may see the drinker’s behavior as fun and share in the drinking episodes. This is the “It can’t happen to me (him/her)” stage. Numerous reasons/rationalizations are found for the drinking and why “the drinker” can’t have a problem.

#### B) Stage 2 — Loss of Self-Respect

Due to the inability to effect change, constant blame and taking responsibility, verbal and/or physical abuse, the family members become increasingly dependent and suffer fear and shame.

#### C) Stage 3 — Collusion

Family excuses and protects the alcoholic from his/her drinking and subsequent consequences. At this point if you can’t beat them you just might join them!

### III. Four Traits of the Enabler

- A) Isolation — social stigma, embarrassment, and fear lead the family to hide the alcoholism. As the disease progresses so does this trait. Outsiders become a threat to expose what is hidden and may label the secrets as alcoholism. If persistent, outsiders may become an enemy of the family system. Family members may exclude each other from individual knowledge. The otherwise collective information of the incidents related to the alcoholism may make it too overwhelming to ignore.

- B) Inconsistency — The family lives with constant doubt and unpredictability with crises and when they will occur. Any hope developed will be followed by disappointment followed by rebuilding hope, etc. There is constant worry over the alcoholic and his/her behavior.
- C) Inadequacy — Either by direct blame from the alcoholic or the inability to ever please enough to effect change, the family member will become the cause of the drinking. This “not being good enough” becomes pervasive.
- D) Indoctrination — The family members are eventually convinced with denial/rationalizations to the point of collusion. Mutual support systems built on lies, etc., develops and the drinking masked.

#### IV. How Enabling Works

- A) The enabler begins with a reaction of “What is wrong with me that they drink or act this way?” Stemming from feelings of inadequacy the enabler begins to change his/her behavior to be “better” for the drinker.
- B) Next the enabler tries to change the immediate environment and balance it to appease the drinker.
- C) Now it's time to take on the whole world, cover up and protect the drinker from consequences.
- D) To do all of this is to compromise one's self, thus, the enablers begin to devalue themselves and build a wall to separate themselves from others.
- E) Next stage is to emotionally withdraw. One may participate in things, verbalize feelings well, but withhold emotionally. Grey days are normal and shame is pervasive.
- F) The pain becomes increasingly strong so the enabler wants to emotionally die. Their moods, feelings, behavior, etc. are dependent upon the drinker's, because of the dependency everything is in reaction to him/her.
- G)) At this point the enabler is starving for affection and will do almost anything to get affection.
- H) Plans to eliminate the drinker for a way out, i.e., fantasize about his/her death, etc. But the enabler continues to manipulate the world just so the drinker will like him.

## INTERVENTION

### INTERVENTION

- I. Definition of Intervention: process and/or event which interferes with, prevents and/or alters the progression of a disease or condition.
  - A. Crisis Intervention: purpose is to provide immediate assistance/aid in order to *lessen* the severity of a crisis situation. This type of intervention occurs immediately after and/or during the crisis. There may or may not be a rehabilitative plan resulting from the crisis intervention.
  - B. Family Intervention: event and process designed to motivate a chemically dependent person/person with a problem to utilize professional help; person is supportively confronted with accurate data concerning his/her disease or condition by a group of concerned others. Concerned others are involved in a series of preparatory and follow-up stages in order to enable them to participate in the family intervention event.
  - C. System Intervention: process designed to change a system dysfunction; the school program is composed of policies and procedures, persons, educational sessions, etc., all of which are steps within the process of a system intervention.



## II. Intervention Process Versus Intervention Event

Examples: Core Group receives information concerning a student intoxicated in class. The intervention process they may engage in could include the following steps:

- I  
N  
T  
E  
R  
V  
E  
N  
T  
I  
O  
N
1. Elicit data from others (teachers, students, counselors, etc.) regarding the incident and the potential scope of the problem.
  2. Meet with student's parents to provide and elicit data.
  3. Meet with student to provide data and elicit data.
  4. Refer the family to Problem Talk Shop for Intervention Classes.
  5. Family completes classes.
  6. Family and concerned others within school rehearse intervention.
- Intervention Event
7. Family and concerned others hold an intervention event with student.
  8. Problem Talk Shop holds follow-up session with family and concerned others; student goes to treatment.
- P  
R  
O  
C  
E  
S  
S

**Intervention Process** always refers to a series of actions, conditions or stages which are designed to intervene with the disease or condition; stages vary; the process does not necessarily end with the intervention event.

**Intervention Event** is always a specific therapeutic session during which the chemically dependent person with a problem is confronted with data concerning his/her disease or condition; the event is designed to motivate the person to accept professional help; the event is always a step within the intervention process. Data is always presented by concerned others in a caring, supportive manner.

## INTERVENTION

### III. History of the Development of Family Intervention

- A. Originally believed that chemical dependency could not be helped until he/she "hit bottom," i.e., until the pain, problems or losses became great enough. "Bottom" was usually skid row and sometimes death.
- B. Next, believed that the "bottom" varied individually; didn't have to reach a physical skid row.
- C. Finally, believed that a "bottom" can be raised or created. Can utilize present harmful consequences to bring about realization of problem and acceptance of professional help.

### IV. Intervention as a Process and Event Is Effective

- A. The strength within intervention results from accurate data and care/concern.
- B. The intervention techniques are adaptable to problems other than chemical dependency.
- C. Intervention should be utilized as a model for confrontation.

## FAMILY INTERVENTION PROCESS APPROPRIATE FOR THE NON-RECOVERING ALCOHOLIC

- I. The first stage of the intervention process entails an assessment of the alcoholic as identified by the concerned other(s) and an assessment of the concerned others(s) in relation to the intervention process.
  - A. Counselor/facilitator must collect data from concerned other(s) about the potential alcoholic/dependent person.
  - B. Counselor/facilitator must determine if the concerned other(s) is (are) appropriate for the intervention process.
    - 1. "Unsupported" emotionally unstable concerned others are *not* appropriate for the intervention process.
    - 2. Concerned others who are not "concerned" are not appropriate for an intervention process.
    - 3. Family members, employers, ministers, and friends are appropriate concerned others.
  - C. If concerned other(s) are not appropriate for intervention process, refer to an appropriate resources.
  - D. If immediate intervention is warranted, do necessary preparation and scheduling.

## INTERVENTION

1. Immediate interventions are appropriate when there is a chemically related crisis which will facilitate the intervention goal.
2. Immediate interventions are appropriate when concerned others have time constraints.
3. Same preparation process utilized, but within a shorter time frame.
- E. If concerned other(s) are appropriate for intervention process, schedule second session of the intervention process (Class I).
  1. Determine which concerned others will be part of the process.
  2. Schedule a date and time.
- II. The second stage (Class I) of the intervention process will provide the concerned others with information on alcoholism including:
  - A. Alcoholism is a chronic, progressive and potentially fatal disease with identifiable symptoms.
  - B. Alcoholism is a multifaceted disease.
  - C. Alcoholics are sincerely deluded.
  - D. Concerned others did not cause the disease and are not "crazy."
  - E. This information about alcoholism lays a "data" framework for the concerned others and facilitates the "concerned person" role and atmosphere.
  - F. Provide the concerned others with reading/homework assignments on the disease of alcoholism.
- III. The third session (Class II) of the intervention process will provide the concerned others with information on alcoholism as a family illness including:
  - A. Alcoholic family systems (primary or extended families) experience a progressive illness process which coincides with disease process of the addicted family member.
  - B. The family illness has identifiable, multifaceted symptoms.
  - C. Concerned others unintentionally enable alcoholism to progress.
  - D. Enabling behaviors need to be changed.
  - E. Provide the concerned others with reading/homework assignments on family illness and enabling materials.

## INTERVENTION

IV. The fourth stage of the intervention process provides the concerned others with instruction for preparing for the intervention event.

- A. Provide a simulation of an intervention event.
- B. Assist the concerned other in preparing data lists.
  - 1. Explain why written data lists are necessary.
  - 2. Provide concerned others with "data" guidelines.
    - a. "Data" are facts/actual events which have been witnessed.
    - b. Time/date information is important.
    - c. Feelings, reactions or consequences of data are relevant.
    - d. All data must be related to drinking/alcoholic behavior.
    - e. Data should be as recent as possible and specific.
    - f. Data should include consumption/control attempt information.
- C. Explain how the data will be presented:
  - 1. Define your role as the guide of the intervention process.
  - 2. Define the role of each concerned other.
  - 3. Define the role of the alcoholic.
  - 4. Explain the rules of the intervention process.
  - 5. Emphasize the need for a caring, concerned atmosphere/attitude.
- D. Assist the concerned others in identifying appropriate intervention referrals/alternatives.
  - 1. Professional treatment services for the alcoholic.
  - 2. Concerned others should select and arrange for treatment services for the alcoholic; i.e., check on insurance, availability of a bed, etc.
  - 3. Concerned others should select and arrange for services/alternatives for themselves.
  - 4. Concerned others should select and arrange for a contingency alternative if the intervention "fails."

V. The fifth intervention stage includes an intervention rehearsal and final arrangements for the intervention event.

- A. Do a simulation of an intervention with the concerned others.

## INTERVENTION

1. Assess and critique the data presented and the mode of presentation.
  2. Make necessary deletions of concerned others from intervention event.
  3. Emphasize the need to avoid labeling the potential alcoholic an "alcoholic."
  4. Reiterate the major "don'ts" of the intervention.
    - a. Don't get into arguments.
    - b. Maintain the caring, concerned atmosphere/attitude.
    - c. Present the data from your list only.
    - d. Present your feelings.
    - e. Don't criticize, judge, or blame.
  5. Make sure the concerned others are aware of the role and part the counselor will take during the intervention.
  6. Decide on seating arrangements.
- B. Decide on a time/place for the intervention.
1. Never do an intervention on the alcoholic's own turf.
  2. Never do an intervention with an intoxicated alcoholic.
- C. Advise the concerned others to finalize plans for referrals/alternatives (i.e., reserve a bed, pack a suitcase, etc.).
- D. Discuss potential reactions and excuses the alcoholic will exhibit during the intervention event.
- E. Discuss the means by which the concerned others will request/motivate the alcoholic to attend the intervention session and role play this request.
- F. Prepare the concerned others for a "failed intervention."
- VI. The sixth stage is the intervention event.
- A. Explain to the alcoholic why he/she is in attendance; ask for a time commitment.
1. Each concerned person presents his/her data list to the alcoholic without interruption.
  2. The alcoholic can respond to each presentation of data.
- B. Establish the rules for the intervention.
- C. Counselor/facilitator closes the data presentation and explains the referrals selected by the concerned others to the alcoholic.
- D. Counselor/facilitator presents contingency alternative if first alternative is rejected.

## INTERVENTION

### VII. Special Issues:

- A. Who is appropriate/inappropriate for an intervention process/event?
  - 1. Unsupported spouse
  - 2. Significant others whom alcoholic dislikes
  - 3. Angry concerned others
  - 4. Children
  - 5. Employer, physician, minister, friends, etc.
- B. What if there is more than one practicing alcoholic/dependent person in the group/family?
- C. How do you maintain confidentiality rights?
- D. Is the process ethical?
- E. What about interventions with adolescents?
- F. What if the intervention "fails"?
- G. Intervention can facilitate the identification and referral of earlier stage alcoholics.
- H. Intervention process can be utilized for "non-recovering" alcoholics in treatment and for other behavioral/health problems.

### INTERVENTION PROCESS USED IN THE SCHOOL SETTING

- I. Always utilize intervention confrontation techniques.
  - A. Present accurate, verified data, relating to the problem.
  - B. Judgments, criticism and speculations should never be a part of the data.
  - C. Maintain a supportive, caring stance regardless of the reaction.
  - D. Provide workable alternatives.
  - E. Remain focused on the identified problem.
  - F. Obtain a commitment for action (hopefully positive).
  - G. Establish time rules or non-interruption rules if necessary.
- II. Utilize intervention confrontation techniques with students, parents, teachers, etc., and regardless of the identified problem.
- III. Do *not* attempt to organize or conduct a family intervention.
  - A. You are not adequately trained.
  - B. You may be asked to participate in an intervention as a concerned other.

## INTERVENTION DATA

**Goal of Intervention:** The goal of an intervention is to present to our chemically addicted person other data about his/her chemical use in a caring and concerned way in order to motivate him/her to obtain professional help. The chemically addicted person is blind to his/her disease and can't see his/her need for help. An intervention allows us to present the reality of the situation to our chemically dependent person in a manner which he/she can accept.

**Data:** The data or facts we are going to present during the intervention should all have the following elements:

1. **Data should be chemically related behaviors, or events.** Example: "Dad, you were drinking last Friday, were stopped by the police, and charged with a D.W.I." It is extremely important that all behaviors are drinking/chemically related. If they are not, then we take the focus off of the fact that our addicted person has a disease for which he/she needs help. (Example: "Dad, last Friday night you were driving recklessly.") Since the reckless driving was not tied to chemical use, i.e., "You were drinking and therefore you drove recklessly. When you are sober, you are a responsible driver," the chemical dependent person can deny that this behavior was unusual ("Everyone breaks the speed limit now and then.") and can deny that the chemicals were the reason for irresponsible driving ("I was upset; it was a rough day; I was in a hurry."). We have to tell the chemically dependent person with every piece of data that it is the chemical use which is the *cause* of his/her problem, and harmful consequences. If we do not tell this directly, the person will continue to deny to himself/herself that the chemical addiction is the disease and is the primary problem for which professional help is needed.
2. **Data should be chemically related events or behaviors which we have witnessed or are sure actually happened:** (Example: "Mom, Tuesday morning you were in the bathroom at 6:00 a.m. I saw you take 5 valium. Your hands were shaking, your face was drawn and you looked scared and sick.") Data is not speculative information. ("I think you are having an affair with another man.") Data can be a report of a drinking/chemical related event which someone else witnessed. ("Your boss called me last week. He said that you have come back from lunch noticeably drunk every day this week.")
3. **Data should include both the harmful consequences and the actual chemical consumption:** Data can be presented about the total consumption ("Mom, you have five prescriptions for valium, all from different doctors. I have counted the number of pills you take each day." "Mom, you take 20 pills a day." Or "Dad, you were at the bars five evenings out of every week this month. Each of these evenings you came home intoxicated. You slurred your words and stumbled." Or "Son, you keep alcohol hidden in your room and your car. You also have drunk 2 bottles of gin from the family liquor supply this week.")

4. **Data should be specified by a date and time:** The more specific we can be about when, where, and with whom an incident happened, the more credible we will be. Also, remember, that the chemically addicted person probably was under the influence during each of these incidences and was not perceiving or sensing accurately or totally. Therefore, we need to give them enough information so that they can remember. Some data we present maybe happened during a blackout, and the addicted person may truly not be able to remember it. Most of the data we present will be remembered by the chemically addicted person. We also need to make the data current, yet comprehensive. Data which happened last week will simply be more effective than data which happened ten years ago. However, if all the data happened this week, the problem tends to be viewed as temporary.
5. **Data should be presented with care and concern:** We need to begin and end each presentation with a statement that says, "I am here because I love you/care about you and I want you to get some help." We should also present our data in a factual but caring manner. Many times the data we discuss will be painful for us to talk about; let the chemically dependent person know that it is difficult.
6. **Data should include the consequences we experienced or feelings we had as a result of a chemically related event/incident:** Data should include your feelings ("I was embarrassed by what you did; I was scared for you or myself; I was angry; I was hurt"). Data should also include consequences you incurred ("I called up your employer and lied for you; I carried you out of the bar; I cleaned up your mess; I asked my parents for money to cover our bills"). Be very careful not to "blame"; tell the truth in a factual manner. Remember, you are responsible for your choices just as the chemically dependent person is responsible for his/her harmful consequences. Let the person know that *you chose* your own reaction or response but also inform him/her that *you* have been adversely affected by the addictive behaviors.
7. **Data should be written:** Bring a written list of all your data to the intervention session. Do not rely on your memory. You will be nervous during the intervention and your nervousness may cause you to forget. Therefore, have your data written on a list and have the list in your hand during the intervention.
8. **Data should point out the contradiction/conflicts in values and behaviors which occur when the chemically dependent person is intoxicated/drugged:** For example, "Joe, you have been a good salesman and good with the customers but this month I received five complaints from customers about your rude and drunken behavior. This isn't like you." Or "You are a good husband and have always treated me with respect. Last Monday you were drunk, and you hit me. You've never hit me before and would never hit me while sober." Data should point out that when intoxicated, they are not the persons they have been or want to be.
9. **Data which verifies attempts to control, quit or change behavior should be prepared:** This data is utilized as needed should the chemically dependent decide he/she can now quit on his/her own, given the new awareness of the problem.

## INTERVENTION

### YOUR INTERVENTION ALTERNATIVES:

You will need to decide upon some alternatives for yourselves and the chemically dependent person. The primary alternative we want to present to the chemically dependent person is to get professional help, preferably inpatient treatment. You have been given a listing of treatment resources in your community and the requirements for admission (gold section). Please review these alternatives and select the alternative which you feel is "best" for your chemically dependent person. Have this alternative selected before you come to the Intervention Session. Your counselor will give you additional assistance in finalizing this alternative during this session. You may want to visit these treatment resources or call them for more information. This is a good idea, but do all of this "checking out" before you attend the Intervention rehearsal.

We also strongly advise you to decide how you will pay for treatment. Check out your insurance policy by calling your agent or calling the company (if it is a group policy). You can also call the CAREUNIT for further help if you have problems or questions about how to check out your insurance policy. If you do not have insurance, find out what your family's financial situation is. Remember, the chemical dependency has most probably injured the finances of the chemically addicted person and possibly your own financial stability. This is a disease which needs to be treated. We need to make as much of an effort to finance chemical dependency treatment as we would to finance the treatment of cancer or diabetes.

You will also need to decide if you want to give the chemically addicted person a "what if" clause or a secondary alternative. The "what if" alternative is used only if the chemically dependent person absolutely refuses the primary alternative. Examples of secondary alternatives are as follows:

1. If you will not go to inpatient treatment, then will you go to outpatient treatment?
2. If you will not go to treatment, then will you agree to stop using alcohol/drugs and attend A.A.? If you use again, will you go to treatment.?

Please think about a secondary alternative. You may decide not to have a secondary alternative. Your counselor will discuss these things with you during Intervention Rehearsal and will help you make some decisions.

The two alternatives we have so far discussed are for the chemically dependent person. You, as a concerned other, will also need to select some alternatives for yourself. You have to decide how you will take care of yourself, regardless of the decision of the chemically dependent person. You may decide to separate from the chemically dependent person if he/she does not go to treatment. This could mean a legal separation or divorce if you are the spouse of a chemically addicted person. It may mean leaving home if you are an adult child of a chemically dependent person. It may mean dismissing or putting on probation a chemically dependent employee, or disassociating yourself from a chemically dependent friend.

The chemically dependent person is in desperate need of professional help which he/she may not want to accept. Separation from the chemically dependent person, when properly motivated, can initiate the beginning of recovery from chemical addiction. However, if you leave in fear, you will return in anxiety. If you leave in anger, you will return in embarrassment and resentment. By first learning all you can about

chemical addiction and practicing non-enabling behaviors, you can leave the chemically addicted person in love, if necessary, rather than waiting for the love to be destroyed. By leaving in love, you free yourself to return at any point when conditions have changed to make a genuine reconciliation possible. This is a decision which you alone can make and it is a decision which should be carefully considered.

These are not threats. These are choices you are making for you and choices which you must be prepared to follow through with. This is also not intentional desertion of the chemically dependent person. These alternatives are your right to live a happy, healthy life. Remember, you cannot change the chemically dependent person or make choices for him/her. You can and must be responsible for yourself and must make choices that insure your health and survival. You cannot give from an empty cup: you cannot help your chemically dependent person if you are an emotional/physical wreck. Therefore, the best thing you can do for yourself and for the chemically dependent person is to take care of *yourself*.

Part of your alternative for yourself is to get some further help and support for you. We suggest that you continue going to Alanon and Alateen meetings. We also have enclosed a listing of professional resources which are for the concerned others of chemically addicted people. Please review these materials and decide what you need for yourself. Again, your counselor will discuss the alternatives you select for yourself, during the Intervention Rehearsal. Please think about this beforehand, and come prepared with your ideas and feelings.

## INTERVENTION

### HOW WILL YOU GET THE CHEMICALLY DEPENDENT PERSON TO ATTEND THE INTERVENTION?

Though this may appear to be an impossibility, where there is a will, there is a way. There are several different ways to request that the chemically dependent person attend the Intervention Session. There is one way which is *not* recommended — physical coercion or force. If physically forced to attend, the chemically dependent person will be too angry to listen.

We do recommend that you verbally ask the chemically dependent persons to attend. You should not, however, inform them that they will be attending an Intervention or explain the purpose of the Intervention to them. For example, you can request that they attend a family counseling session to discuss problems the entire family has been experiencing or request that they accompany you to see a counselor to discuss some problems which you have been having which also affect them. Do not mention the chemicals or drinking; avoid telling the chemically dependent persons that the focus of the session will be their chemical use.

If the chemically dependent person would be resistant to the direct request, you may consider holding the Intervention at his/her place of employment or school and utilizing the assistance of the employer or school counselor to get him/her to attend.

You will be discussing this issue with your counselor during the Rehearsal Session, and your counselor will help you plan and practice this request. For now, please just consider how and who should request the chemically dependent person to attend the Intervention Session. Also realize that we are serious when we tell you that this is rarely a problem; concerned others usually find a way and means to get the chemically dependent person to voluntarily attend the Intervention Session.

### WHEN AND WHERE WILL THE INTERVENTION BE HELD?

We want to do the Intervention as soon as possible. There are reasons for our urgency. First of all, you as a concerned other are prepared and ready. If you procrastinate, you may forget the things which you have learned about doing an Intervention. Secondly, chemical dependency is a progressive disease. We need to intervene as soon as possible; it is a matter of life and death.

The Intervention should be held at the time of day during which the chemically dependent person is sober. For some of you, this will mean that the Intervention will have to take place in the early morning or on a weekday rather than a weekend. You know the chemical use patterns of your chemically dependent person and need to consider these patterns when deciding on the Intervention time. You also need to consider the schedules of the concerned others who will be participating in the Intervention.

We prefer to do the Intervention at the CAREUNIT in your counselor's office. If it is necessary, an employer's office, doctor's office or some other "neutral" place is appropriate. Interventions should not be done in the chemically dependent persons' home or office; they will be more likely to leave the Intervention if it is done in their own environments.

Your Intervention Counselor will help you select the best time and place for the Intervention Session. For now, we would like you to consider these things, and to do some preliminary planning before your Intervention Rehearsal.

## INTERVENTION

### WHY INTERVENTION AS A CONFRONTATION IS DIFFERENT.

Chances are that your Intervention Session will not be the first time that you and others have tried to confront the chemically addicted person with the reality of his/her situation. You have probably discussed and presented him/her with facts about his/her chemical use and the harmful consequences of this chemical use before. Some of these confrontations may have included threatening the chemically dependent person with the loss of his/her job or family if he/she did not change. Chances are, many of these past confrontations ended up in family arguments or apologies or tears or promises. As time passed, however, the promises were broken, the discussions were forgotten and/or the threats were not carried out. In short, the confrontations did not seem to bring about any lasting positive changes.

Intervention is different from these past confrontations and it is these differences which make it effective. First of all, care, concern and support are provided during the intervention. The chemically dependent person's defensiveness is reduced due to the feeling that everyone is trying to help and not hurt. He/she does not have to respond in anger or hide behind tears or silence, and so can listen to what is being said and can be assured that the support will always be there. Because the concerned others do not blame, judge or criticize, the chemically dependent person does not feel attacked and does not feel the need to shield himself/herself from both the people and the words.

The information which is presented during the intervention is all chemically related data. We focus on the harmful consequences of the chemical use and give specific, accurate true accounts of these harmful consequences. We do not discuss behaviors or weaknesses which are not related to the chemical use.

By keeping the focus on the drinking/drug behavior, we tell the chemically addicted person over and over again that it is the chemicals which are causing the problems. In essence, we state and document the existence of the disease, and we encourage the addicted person may have agreed to get professional help, but may either have changed on the disease, we end up telling our chemically addicted person that he/she has many different problems, all of which need a separate solution. We overwhelm the chemically addicted person with requests for change. He/she is not only confused by all of these requests, but honestly does not know where to begin or what to change first.

Alternatives for the chemically addicted person and for the concerned others are arranged prior to the Intervention Session. In past confrontations, the chemically addicted person may have agreed to get professional help, but may either have changed his/her mind the following day or hour or may simply never have followed through with the commitment. By prearranging alternatives for professional help, we remove the opportunity for the chemically addicted person to change his/her mind or to procrastinate. By making arrangements for the alternatives which we as concerned others select, we also force ourselves to take positive action, to do something rather than just threaten.

## INTERVENTION

# INTERVENTION

### OUTLINE:

#### I. IDENTIFYING THE ILLNESS

- A. Other problems tend to shield the alcoholism from being recognized and diagnosed.
- B. Drinking episodes are progressively increasing symptoms of the addiction — the primary problem to be dealt with.

#### II. IDENTIFYING “KEY PERSONS” WHO SURROUND THE ALCOHOLIC

- A. Two basic questions:
  - 1. Who are the meaningful persons surrounding the alcoholic?
  - 2. Can they gather in my office?
- B. Gathering this group of persons is an attempt to achieve two goals.
  - 1. Accumulate enough data to demonstrate without a doubt the presence of the progressively worsening disease of alcoholism.
  - 2. Motivate the persons who could best present this data to the alcoholic.

#### III. INTERVENTION TRAINING OF THE “KEY PERSON”

Two basic goals of training sessions:

- A. Evaluate these people in two areas.
  - 1. Do they know enough about the illness of alcoholism to see that the alcoholic is unable to seek help voluntarily?
  - 2. Are these people emotionally adequate to be interveners?
- B. Prepare the people specifically for the Intervention scene.
  - 1. Prepare written lists of specific incidents or conditions (first-hand information).
  - 2. Become aware of various alternatives in the continuum of care which could be offered to the alcoholic, and agree on which alternatives to be offered.
  - 3. Predict alcoholic's most likely excuses and attempt to meet them in advance.
  - 4. Simulate forthcoming intervention session. Select a chairperson and define responsibilities of this role as follows:
    - a. Stating purpose of meeting.
    - b. Summarizing how these people are gathered for this meeting.
    - c. Setting the ground rules for the meeting.
    - d. Beginning the process of presentation of data by selecting the order of presentations.
    - e. Closing the session by summarizing the concerns of the group and offering the choices of care that the group agreed upon in advance.

## IV. CONCLUSION

- A. The counselor is an evaluator who assesses:
  1. The severity of the illness as described by the concerned person.
  2. What knowledge about the nature and dynamics of the illness must be presented to the concerned persons in order to help them be more effective interveners.
  3. The emotional stability of each of the concerned persons. By doing this the counselor is able to eliminate the potential counterproductive interveners and also select the person who could best be the chairperson of the intervention session.
- B. The counselor is an educator who trains the concerned person by:
  1. Providing information about the nature and dynamics of the disease.
  2. Describing the principles and specific techniques of the intervention process.
  3. Selecting and then equipping the chairperson with additional information about this role in the intervention process.
  4. Listing the various alternatives in the continuum of care that could be offered to the alcoholic.
  5. Assisting the interveners in selecting the most appropriate alternatives that they will offer the alcoholic.
  6. Simulating the intervention session in order to better prepare the persons for the actual one.

## CHECK LIST

1. Who are the most meaningful persons around the alcoholic?
2. Could you gather them together?
3. Do *they* know enough about the nature of alcoholism to accept the basic facts that the alcoholic is incapable of recognizing the true nature of his condition and, therefore, is unable to seek help voluntarily?
4. Are these people emotionally adequate to be interveners?
5. Are these people prepared specifically for the intervention session?

## INTERVENTION

6. Do these people have a written list of *specific* incidents or conditions which legitimize their concern?
7. Does the data legitimize the concern which is being expressed?
8. Is the group familiar with various alternatives in the continuum of care which could be offered to the alcoholic?
9. Can the group predict what will be the alcoholic's most likely excuses for not accepting the choices being offered, and attempt to meet them in advance?
10. Has the group been rehearsed by simulating the forthcoming intervention session?
11. Have you eliminated a person or persons from the group who you feel would not be useful?
12. Is there a "chairman" for the intervention?
13. Is the chairman aware of his task of setting the "ground rules" for the meeting, and bringing it to closure?

## INTERVENTION SERVICES: SCHOOL APPROACH

The reason for establishing an intervention process within the school is to allow for systematic identification of students who demonstrate inappropriate behavior. In many cases a pattern of inappropriate behavior is symptomatic of a more serious, underlying problem. The intervention process assists in early identification of unacceptable behaviors and provides a method for handling subsequent concerns by the staff. In the intervention process teachers are not asked to be diagnosticians, but rather to use their expertise in identifying appropriate versus inappropriate behavior. A teacher's knowledge and understanding of this process and the ability to apply it to the classroom and school situations will be the first step in assisting students to enrich and improve their lives.

### I. Setting Up an Intervention System

A. Establish district and school policies regarding intervention services which include the following:

1. A support statement for intervening in situations where student behavior is unacceptable.
2. How to identify unacceptable behavior.
3. List of options available for employee to suggest corrective measures.
4. Disciplinary procedures
  - a. Possession of drugs/alcohol
  - b. Sale and/or distribution of drugs/alcohol
  - c. Under the influence of drugs/alcohol
  - d. Defiance
  - e. Other

B. Characteristics of the Intervention Process

1. Supportive
2. Non-punitive
3. Non-judgmental
4. Non-rescuing, avoid professional enabling
5. Known by the students, staff and parents
6. Well structured but developed with enough flexibility to respond to unique needs and situations.

## INTERVENTION SERVICES

C. Forms: (color coding of forms #1 and #2 (see attached) will help avoid confusion). Each staff member receives a supply of form #1 to be used when necessary. Form #2 is to be kept on file with the Core Team to be sent out upon receipt of a referral.

1. Form #1—student referral to the Core Team
2. Form #2—staff response form
3. Team report of student profile

D. Intervention Team Members

1. Must have completed appropriate training
2. Must hold an appropriate position, i.e., counselor, administrator, school psychologist
3. Must be able to effect disciplinary action, if necessary
4. Must commit to attend meetings as necessary

E. Types of Referrals

1. Parental referral
  - a. Parent expresses concern about the student's behavior, i.e., finds drugs, student is a runaway, incorrigible.
  - b. Parent expresses inability to control the situation.
2. Self-referral by the student.
  - a. Student expresses concern about his/her own behavior or concerns about family issues.
  - b. Student expresses concern about a friend's behavior.
3. Referral by staff member
  - a. Identification and documentation of inappropriate/unacceptable behavior by a staff member.
  - b. Witnessed drug/alcohol use is reported immediately and consistently to the appropriate administrator.
  - c. Suspected use is reported to the Core Team.
4. Referral by outside agency (police, probation, social services)
  - a. May express concern to school employee over student and/or family.
  - b. May request cooperation of Core Team in their work with the student and/or family.
  - c. May offer service to compliment intervention process.

## INTERVENTION SERVICES

### F. Faculty Inservice and Staff Development

#### 1. Programs should include:

- a. Full explanation of the intervention process, how it works and what the expected outcome may be.
- b. How the intervention process can improve classroom and school climate.
- c. How to utilize appropriately the referral system forms and how to use **objective** data at all times.
- d. How to know when to deal with students' personal problems and when to refer to the Core Team.
- e. How teachers can deal with fears and uncertainty about making referrals.
- f. Explanation of all district and school policies related to substance abuse.
- g. Disposition of cases
  - 1) General guidelines for determining the disposition of the case
  - 2) Core Team must develop referral resources
    - a) Support groups, counselor, school psychologist, significant other, etc.
    - b) Outside agencies—Problem Talk Shop, County Mental Health, Alanon, A.A., Alateen, Youth Services Program (Y.S.P.), etc.

## INTERVENTION SERVICES

### II. How an Intervention Process Works

- A. A staff member becomes concerned about inappropriate behavior he/she has observed: increased tardiness, absenteeism, lowered class performance, outbursts in class, apathy, increased complaints of illness, etc.
- B. If a staff member chooses to speak directly with the student, and if satisfactory results are achieved, no further steps need to be taken. However, since most staff members only observe a student for part of his/her day, the referring staff member may wish to explore the student's behavior in other classes further, or at least record this incident for future reference.
- C. A supply of form #1 is at the disposal of all staff members for referral or recording purposes. This form is to be completed as objectively as possible. The completed form is sent immediately to the Core Team member responsible for intervention services.

Examples of "objective" referrals are:

- 1. "John has been absent from my class four times in the last two weeks. Two of his absences were unexcused."
- 2. "Bob's grade has dropped from a 'B' to a 'D' in my class. He is unwilling to discuss this with me."
- 3. "Jane has had an outburst in my class of crying and using obscene language today. This is the second such outburst this month."

Speculative remarks or remarks which label the student are to be avoided. Examples of inappropriate referrals are:

- 1. "Jane's been acting very strange lately, I think she's getting loaded."
  - 2. "Bob just keeps messing up my class. He is a jerk!"
  - 3. "I bet John is just skipping school to get drunk."
- D. Upon receiving a student referral the Intervention Team members meet to decide which step to take next. After consideration of the information received and the goal of the referring staff member, the following options are available:
    - 1. The intervention services files should be checked to determine whether a prior referral has been made regarding the student.
    - 2. File the referral for future reference.

## INTERVENTION SERVICES

3. Submit the referral to the student's counselor/school psychologist for a one-on-one counseling session.
4. Submit the referral to the Dean of Students for disciplinary action.
5. Initiate the gathering of data from other staff by distributing form #2 (staff member response form) to the student's other teachers, counselor, school nurse, attendance office, etc. These forms should be completed as soon as possible, within 24 hours and returned in a sealed, confidential envelope to the identified Core Team member. After receiving these forms, the Intervention Team meets to complete the student profile.
6. Upon completion of the student profile, a desired goal for further action is established. All further action is directed toward this goal:
  - a. Meet with the student and/or parents.
  - b. Hold rehearsal intervention session to increase awareness of staff concerns.
  - c. Refer student to a support group or information classes.
  - d. Refer student/family to outside agency for assessment.
7. Follow-up procedure is essential. Immediately following the meeting, a Core team member is to report the case disposition to the referring staff member. Additional information is reported as received.

## SUMMARY

The process of intervention, though originally intended only for chemical misuse/abuse problems, is applicable whenever concern is expressed over a student's inappropriate or unacceptable behavior. This format is a suggested guideline for a school's Intervention Services. It should be remembered that the intervention process is in the best interest of the student. It is not a diagnostic or labeling process, nor is it a treatment procedure. It is the initial step in getting help for students and families. To maximize its potential and usefulness the process must be adapted so that it becomes a part of the school's policies and procedures.

## TWENTY QUESTIONS FOR PARENTS

ANSWER YES OR NO:

1. Do you worry about your child's chemical use? \_\_\_\_\_
2. Have you ever been embarrassed by your child's chemical use? \_\_\_\_\_
3. Are holidays more of a nightmare than a celebration? \_\_\_\_\_
4. Are most of your child's friends heavy drinkers or users? \_\_\_\_\_
5. Does your child often promise to quit using chemicals? \_\_\_\_\_
6. Does your child's chemical use make the atmosphere in the home tense or anxious? \_\_\_\_\_
7. Does your child deny a chemical problem because he or she drinks only beer or only smokes pot? \_\_\_\_\_
8. Do you find it necessary to lie to employer, relatives, school or friends in order to hide you child's chemical use? \_\_\_\_\_
9. Has your child ever failed to remember what occurred during a period of chemical use? \_\_\_\_\_
10. Does your child talk about chemicals, or situations in which they are used a lot? \_\_\_\_\_
11. Does you child justify his or her chemical problem? \_\_\_\_\_
12. Does your child avoid social situations where chemicals will not be available? \_\_\_\_\_
13. LDo you ever feel guilty about you child's chemical use? \_\_\_\_\_
14. Has your child driven a vehicle while under the influence of alcohol or other drugs? \_\_\_\_\_
15. Are you afraif of your child while he is drinking or using chemicals? \_\_\_\_\_
16. Are you afraid of physical or verbal abuse when your child is drinking or using chemicals? \_\_\_\_\_
17. Has another person mentioned your child's unusual behavior? \_\_\_\_\_
18. Do you worry about your child's driving safety because he or she may be using chemicals? \_\_\_\_\_
19. Does your child have periods of remorse after using chemicals and appologize for behavior? \_\_\_\_\_
20. Do you notice rapid up and down personality changes or mood swings in your child? \_\_\_\_\_

## ADOLESCENT CHEMICAL USE QUESTIONNAIRE

Answer YES or NO

1. Are you ever absent from school because of drinking or using drugs? \_\_\_\_\_
2. Do you need chemicals to make you feel better around other people? \_\_\_\_\_
3. Do you ever hide your chemicals? \_\_\_\_\_
4. Do you feel less afraid when you use chemicals? \_\_\_\_\_
5. Do you ever use chemicals alone? \_\_\_\_\_
6. Do you use chemicals as a way to stop worrying, to forget problems? \_\_\_\_\_
7. Do you ever feel guilty about your use of chemicals? \_\_\_\_\_
8. Do you wish people would mind their own business about you use? \_\_\_\_\_
9. Is it necessary for you to use chemicals in order to have fun? \_\_\_\_\_
10. Does drinking/using make you feel equal to other kids? \_\_\_\_\_
11. Do you sneak drinks from your parents' supply or from someone else's? \_\_\_\_\_
12. Did you ever steal money or objects in order to buy chemicals? \_\_\_\_\_
13. Have you ever paid anyone to get your chemicals for you? \_\_\_\_\_
14. Have you stayed away from the "straight" kids since you started using? \_\_\_\_\_
15. Do you hang around with kids who use? \_\_\_\_\_
16. Do most of your friends use less than you do? \_\_\_\_\_
17. Do you use chemicals until you are high, stoned, or drunk? \_\_\_\_\_
18. Have you ever forgotten what happened while you were high or drunk? \_\_\_\_\_
19. Have you ever been arrested because of chemicals? \_\_\_\_\_
20. Do you think you have a problem with chemicals? \_\_\_\_\_
21. Have you ever decided to stop using for a week but only lasted a few days? \_\_\_\_\_
22. Have you ever switched from one kind of chemical to another in hope that this would keep you from getting into hassles with your use? \_\_\_\_\_
23. Have you used chemicals in the morning during the past year? \_\_\_\_\_
24. Do you envy people who can use without getting into trouble? \_\_\_\_\_
25. Have you had problems connected with your use during the past year? \_\_\_\_\_

26. Has your use caused trouble at home or school? \_\_\_\_\_
27. Do you tell yourself you can stop using any time you want to even though you keep getting high or drunk when you don't mean to? \_\_\_\_\_
28. Have you ever felt that your life would be better if you could stop using or at least control your using? \_\_\_\_\_
29. Have you ever been in a car accident while drinking or using? \_\_\_\_\_
30. Have you ever lost a job or almost lost a job because of chemicals? \_\_\_\_\_
31. Have your grades suffered since you started using chemicals? \_\_\_\_\_
32. Have you ever gotten into an argument or fight when using chemicals? \_\_\_\_\_
33. Has your use of chemicals affected your reputation? \_\_\_\_\_
34. Have you ever stayed high for a day or more? \_\_\_\_\_
35. Have you ever borrowed money or done without something in order to buy chemicals? \_\_\_\_\_
36. When in school, home or at work do you think of when you can get high again? \_\_\_\_\_
37. Do you sometimes try to cut down on your use of chemicals? \_\_\_\_\_
38. Do you sometimes feel very alone and lonely? \_\_\_\_\_
39. Are you more "touchy" or sensitive since you started using? \_\_\_\_\_
40. Have you ever had thoughts of running away or of suicide since you started using? \_\_\_\_\_

## ADOLESCENT'S SELF EVALUATION

Listed below are questions about drugs and use. Answer YES or NO to the ones that apply to you or have ever applied to you.

1. I use drugs on a regular basis. \_\_\_\_\_
2. I drink to get drunk. \_\_\_\_\_
3. I use drugs to get high. \_\_\_\_\_
4. Getting high is something that is important to me. \_\_\_\_\_
5. I look for parties or people to get high with. \_\_\_\_\_
6. I avoid straight people. \_\_\_\_\_
7. I have used alone. \_\_\_\_\_
8. I have misused prescriptions in order to get high. \_\_\_\_\_
9. I have used drugs to relieve tension. \_\_\_\_\_
10. I have used drugs because I was feeling bad and wanted to feel better. \_\_\_\_\_
11. People have said that my personality has changed since I started using drugs. \_\_\_\_\_
12. I have made changes in my life so I could continue to use drugs. \_\_\_\_\_
13. I have used people in order to get drugs or get high. \_\_\_\_\_
14. I look forward to times when I can use drugs. \_\_\_\_\_
15. I get worried or uneasy when I can't get drugs or when they start to run out. \_\_\_\_\_
16. I have stored up or layed away a drug supply just in case I run out. \_\_\_\_\_
17. I have kept a stash that is just for me. \_\_\_\_\_
18. I like to talk about what drugs do for me. \_\_\_\_\_
19. I have lied about how much and how often I use. \_\_\_\_\_
20. I get restless or uneasy if something interferes with my plans to get high. \_\_\_\_\_
21. I like to "get off" as quickly as possible. \_\_\_\_\_
22. I smoke grass and drink alcohol together. \_\_\_\_\_
23. I chain smoke grass so I can "get off" better. \_\_\_\_\_
24. Sometimes I can't explain why I get high - I just do. \_\_\_\_\_
25. I have changed plans in order to get high. \_\_\_\_\_

26. There have been times when I have used more drugs than I planned to. \_\_\_\_\_
27. I have broken promises to myself or others to change my drug use. \_\_\_\_\_
28. I have broken promises to myself or others to quit using. \_\_\_\_\_
29. It takes more drugs for me to get the kind of high I want. \_\_\_\_\_
30. I can handle my high even if I have taken more drugs than I planned to. \_\_\_\_\_
31. I can drink more than my friends. \_\_\_\_\_
32. I don't feel that my drug problem is as serious as people think. \_\_\_\_\_
33. I feel that I have my drug use under control. \_\_\_\_\_
34. I get angry when people say that I have a drug problem.
35. I could stay straight if it wasn't for my friends.
36. I don't like to think of some of the things I have done while under the influence of drugs. \_\_\_\_\_
37. Drugs interfere with my life. \_\_\_\_\_
38. I sneak use so people won't know how much I'm getting high. \_\_\_\_\_
39. When I run out of drugs I will run around looking for more. \_\_\_\_\_

## ADOLESCENT CHEMICAL USE QUESTIONNAIRE HARMFUL CONSEQUENCES

Answer YES or NO to the statements that apply to you or have ever applied to you.

### FINANCIAL

1. I am broke because I use money to get drugs. \_\_\_\_\_
2. I owe people money for drugs. \_\_\_\_\_
3. I steal in order to get money for drugs. \_\_\_\_\_
4. I have sold things in order to get money for drugs. \_\_\_\_\_
5. I have put off buying things I need in order to get money for drugs. \_\_\_\_\_
6. I gamble in order to get money for drugs. \_\_\_\_\_
7. I deal in order to get money for drugs. \_\_\_\_\_
8. I have done things I am ashamed of in order to get money for drugs. \_\_\_\_\_
9. Most of my money goes for drugs. \_\_\_\_\_

### FRIENDS

1. I have lost a friend because of my use. \_\_\_\_\_
2. My girlfriend/boyfriend expressed concern about my drug use. \_\_\_\_\_
3. I've changed friends to be with people who use like I do. \_\_\_\_\_
4. My friends call me "burn out." \_\_\_\_\_
5. I've gotten into fights with my friends about my drug use. \_\_\_\_\_
6. I've done things to my friends, while high, that I have regretted afterwards. \_\_\_\_\_
7. I've made plans to be with friends, and then cancelled them, so that I could get high. \_\_\_\_\_
8. I've lied to friends about how much I use. \_\_\_\_\_
9. My friends have avoided me since I started using drugs. \_\_\_\_\_
10. If I had a choice between being with my straight friends or getting high, I would get high. \_\_\_\_\_
11. I've endangered the lives of my friends through my drug use. (driving while drunk) \_\_\_\_\_

## SCHOOL

1. I've been caught with drugs in school. \_\_\_\_\_
2. I've been suspended from school because of my drug use. \_\_\_\_\_
3. My grades have gone down since I started using drugs. \_\_\_\_\_
4. I skip school to get high. \_\_\_\_\_
5. I skip school more often since I started using drugs. \_\_\_\_\_
6. I don't care that much about school since I started using drugs. \_\_\_\_\_
7. I've gotten a reputation in school as being a drug user. \_\_\_\_\_
8. I can't concentrate on school as well since I started using drugs. \_\_\_\_\_
9. I have stolen things in school in order to get money to get high. \_\_\_\_\_
10. A teacher or counselor has asked me about my drug use. \_\_\_\_\_
11. I've been referred to drug evaluation by the school. \_\_\_\_\_
12. A counselor at school has told me to get help for my drug problem. \_\_\_\_\_

## LEGAL

1. I've committed crimes while under the influence of drugs. \_\_\_\_\_
2. I've been arrested for a crime while under the influence of drugs. \_\_\_\_\_
3. The only time I commit crimes is when I'm under the influence of drugs. \_\_\_\_\_
4. I've been arrested for drug offenses. (DUI, dealing, possession). \_\_\_\_\_
5. I commit crimes to get money for drugs. \_\_\_\_\_
6. All my legal problems are drug related. \_\_\_\_\_
7. The court/probation officer ordered that I have a drug evaluation. \_\_\_\_\_
8. I have been court ordered to treatment. \_\_\_\_\_
9. I have gotten into a fight with a police officer while under the influence of drugs. \_\_\_\_\_
10. My criminal behavior started after I began using drugs. \_\_\_\_\_

## FAMILY

1. My parents have hassled me about my drug use. \_\_\_\_\_
2. I lie to my family about my drug use. \_\_\_\_\_
3. I fight with my parents about my drug use. \_\_\_\_\_
4. My parents wait up for me to see if I'm high. \_\_\_\_\_
5. My parents don't trust me since I started using drugs. \_\_\_\_\_
6. My brother/sister calls me a "burn out." \_\_\_\_\_
7. My brother/sister has expressed concern about my drug use. \_\_\_\_\_
8. I find it harder to talk to members of my family since I started using drugs. \_\_\_\_\_
9. I avoid family functions because I's rather get high. \_\_\_\_\_
10. My brother/sister calls my friends "burn outs." \_\_\_\_\_

## PERSONAL

1. I've done things that I am ashamed of while under the influence of chemicals. \_\_\_\_\_
2. I've given up interest, sports - hobbies, since I started using chemicals \_\_\_\_\_
3. I've had a blackout. \_\_\_\_\_
4. My memory isn't as good as it was before I started using drugs. \_\_\_\_\_
5. I get anxious if I run out of chemicals. \_\_\_\_\_
6. Since I started using chemicals I don't care about anything any more. \_\_\_\_\_
7. My goals have changed since I started using drugs. \_\_\_\_\_
8. My values have changed since I started using drugs. \_\_\_\_\_
9. I've hurt myself physically while under the influence of drugs (accidents). \_\_\_\_\_
10. I find it harder to talk to people about my problems since I started using drugs. \_\_\_\_\_
11. I've done things while under the influence of drugs that, when I thought about them later, really scared me. \_\_\_\_\_
12. I have overdosed on drugs. \_\_\_\_\_
13. I've been hospitalized for an overdose. \_\_\_\_\_
14. I have overdosed on purpose. \_\_\_\_\_
15. I have thought about suicide seriously. \_\_\_\_\_
16. I have tried to commit suicide. \_\_\_\_\_

TREATMENT  
&  
RECOVERY



## AND NOW THE JOURNEY BEGINS . . .

### The Process of Recovery

Unless there is an ongoing recovery process a chemically dependent person may not be using, but can experience symptoms which need treatment or he/she will die psychologically—much like the actively using chemically dependent person would die physically without intervention.

There are danger signs you need to recognize in order to intervene on the “dry alcoholic.”

#### I. Behavior: building an image of importance and having it all together

- A. A display of self-importance
  - Me, myself and I
  - Put downs/humor
  - Manipulation of support
- B. Grandiosity
  - Making it **big on own**
  - No test, no support, no fear
  - Having it all together
  - Having all the answers—all talk, little action

#### II. Feelings: “I’m feeling uncomfortable.”

- A. Feelings:
  - Inadequacy                      Constantly proving
  - Guilt                              there is nothing wrong;
  - Fear                                EMOTIONAL PAIN
  - Anger
- B. Unaware — Feelings are unavailable covered by self-centeredness and arrogance.
- C. Unresponsive—feels nothing

#### III. Survival

- A. Sincere delusions—uses defenses to survive
- B. Rigidity
  - Intolerant                      Judgmental
  - Fault-finding                  Perfectionistic
  - Rationalizing                Projecting
  - Justifying

## AND NOW THE JOURNEY BEGINS . . .

C. Denial

IV. Hitting Bottom—delusion of control.

A. Alienation

B. Loneliness—even with friends because there is no sharing of feelings.

C. “Time Bomb”—lets out steam like a pressure cooker (bits and pieces of emotional pain a little at a time to different people—can’t risk.)

D. No freshness or creativity—can’t risk failure.

E. Unable to change or grow—fear of discovery.

RESULT:

Return to use or psychological death

INTERVENTION FOR CHANGE:

V. Recovery:

A. A process of getting back to reality and you

B. Self-acceptance

powerless, unmanageable  
personal inventory of feelings  
realizing my strengths

C. Pride in small steps

D. Acceptance—both joy and pain; growth, change

## THIS IS A. A.

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions.

A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes.

Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

## WHO WE ARE

We in A.A. are men and women who have discovered, and admitted, that we cannot control alcohol. We have learned that we must live without it, if we are to avoid disaster for ourselves and those close to us.

With local groups in thousands of communities, we are part of an informal international fellowship with members in more than 90 countries. We have but one primary purpose: to stay sober ourselves and to help others who may turn to us for help in achieving sobriety.

We are not reformers, and we are not allied with any group, cause or religious denomination. We have no wish to dry up the world. We do not recruit new members, but do welcome them. We do not impose our experience with problem drinking on others, but we do share it when we are asked to do so.

Within our membership may be found men and women of all ages and many different social, economic and cultural backgrounds. Some of us drank for many years before coming to the realization we could not handle alcohol. Others were fortunate enough to appreciate, early in life or in their drinking careers, that alcohol had become unmanageable.

The consequences of our alcoholic drinking have also varied. A few of us had become derelicts before turning to A.A. for help. Some had lost family, possessions, and self-respect. We had been on "skid row" in many cities. Some of us had been hospitalized or jailed times without number. We had committed grave offenses - against society, our families, our employers, and ourselves.

Others among us have never been jailed or hospitalized. Nor had we lost jobs or families through drinking. But we finally came to a point where we realized that alcohol was interfering with normal living. When we discovered that we could not live without alcohol, we too sought help through A.A.

All the great faiths are represented in our Fellowship and many religious leaders have encouraged our growth. There are even a few self-proclaimed atheists and agnostics among us. Belief in, or adherence to, a formal creed is not a condition of membership.

We are united by our common problem, alcohol. Meeting and talking and helping other alcoholics together, we are somehow able to stay sober and to lose the compulsion to drink, once a dominant force in our lives.

We do not think we are the only people who have the answer to problem drinking. We know that the A.A. program works for us and we have seen it work for every newcomer, almost without exception, who honestly and sincerely wanted to quit drinking.

Through A.A., we have learned a number of things about alcoholism and about ourselves. We try to keep these facts fresh in our thinking at all times because they seem to be the key to our sobriety. For us, sobriety must always come first.

### WE MADE A DECISION

All of us now in A.A. had to make one crucial decision before we felt secure in the new program of life without alcohol. We had to face the facts about ourselves and our drinking realistically and honestly. We had to admit that we were powerless over alcohol. For some of us, this was the toughest proposition we had ever faced.

We did not know too much about alcoholism. We had our own idea about the word "alcoholic". We tied it up with the down-and-out derelict. We thought it surely meant weakness of will, weakness of character. Some of us fought off the step of admitting that we were alcoholics. Others only partially admitted it.

Most of us, however, were relieved when it was explained to us that alcoholism was an illness. We saw the common sense of doing something about an illness that threatened to destroy us. We quit trying to deceive others - and ourselves - into thinking that we could handle alcohol when all the facts pointed the other way.

We were told from the beginning that no one could tell us that we were alcoholics. The admission had to come from us - not from a doctor or minister or wife or husband. It had to be based on facts which we knew to be true. Our friends might understand the nature of our problem, but we were the only ones who could tell for sure whether or not our drinking was out of control.

Frequently we asked: "How can I tell if I am really an alcoholic?" We were told that there were no hard and fast rules for determining alcoholism. We learned that there were, however, certain tell-tale symptoms. If we got drunk when we had every reason to stay sober, if our drinking had become progressively worse, if we no longer got as much fun from drinking as we once had - this, we learned, were apt to be symptoms of the illness we call alcoholism. Reviewing our drinking experiences and their consequences, most of us were able to discover additional reasons for recognizing the truth about ourselves.

Quite naturally, the prospect of a life without alcohol seemed a scary one. We feared that our new friends in A.A. would be dull or, worse yet, wild-eyed evangelists. We discovered that they were, instead, human beings like ourselves. But with the special virtue of understanding our problem - sympathetically, without sitting in judgment. We began to wonder what we had to do to stay sober, what membership in A.A. would cost and who "ran" the organization locally and worldwide. We soon discovered that there are no "musts" in A.A., that no one is required to follow any formal ritual or pattern of living. We learned also that A.A. has no dues or fees of any kind; expenses of meeting rooms, refreshments and literature are met by passing the hat. But even contributions of this kind are not a requirement of membership.

It soon became apparent to us that A.A. has only a minimum of organization and has nobody giving orders. Arrangements for meetings are handled by group officers who move on regularly to make room for new people. This "rotation" system is very popular in A.A.

### STAYING SOBER

How, then, do we manage to stay sober in such an informal, loosely-knit fellowship?

The answer is that, once having achieved sobriety, we try to preserve it by observing and following the successful experience of those who have preceded us in A.A.

Their experience provides certain "tools" and guides which we are free to accept or reject, as we may choose. Because our sobriety is the most important thing in our lives today, we think it wise to

follow the patterns suggested by those who have already demonstrated that the A.A. recovery program really works.

### THE 24-HOUR PLAN

For example, we take no pledges; we don't say that we will "never" drink again. Instead, we try to follow what we call the "twenty-Four Hour plan". We concentrate on keeping sober just the current 24 hours. We simply try to get through one day at a time without a drink. If we feel the urge for a drink, we neither yield nor resist. We merely put off taking that particular drink until tomorrow.

We try to keep our thinking honest and realistic where alcohol is concerned. If we are tempted to drink - and the temptation usually fades after the first few months in A.A. - we ask ourselves whether the particular drink we have in mind would be worth all the consequences we have experienced from drinking in the past. We bear in mind that we are perfectly free to get drunk, if we want to, that the choice between drinking and nondrinking is entirely up to us. Most important of all, we try to face up to the fact that, no matter how long we may have been dry, we will always be alcoholics - and alcoholics, as far as we know, can never again drink socially or normally.

We follow the experiences of the successful "oldtimers" in another respect. We usually keep coming regularly to meetings of the local A.A. group with which we have become affiliated. There is no rule which makes such attendance compulsory. Nor can we always explain why we seem to get a lift out of hearing the personal stories and interpretations of other members. Most of us, however, feel that attendance at meetings and other informal contacts with fellow A.A.'s are important factors in the maintenance of our sobriety.

### WHERE TO FIND A.A.

A.A. help is available without charge or obligation. There are groups of us in many cities, villages and rural areas throughout the world. Many groups are listed in the community telephone directory and information about local meetings may often be obtained from doctors and nurses, from the clergy, newspaper people, police officials, and others who are familiar with our program. In many cities there are alcoholism treatment centers that know about A.A. Those who cannot get in touch with a group in their community are invited to write to the world service office: ALCOHOLICS ANONYMOUS, Box 459 Grand Central Station, New York, NY, 10017. They will put you in touch with the group nearest you. Should you live in a remote area and there is no nearby group, they will tell you how a number of "lone" members are staying sober by using A.A. principles and the A.A. program.

### ANYONE WHO TURNS TO A.A. CAN BE ASSURED THAT HIS OR HER ANONYMITY WILL BE PROTECTED.

If you feel that you may have an alcoholic problem and earnestly want to stop drinking, more than 650,000 of us can testify that A.A. is working for us - and that there is no reason in the world why it would not work for you.

Copyright 1953, Alcoholics Anonymous Publishing, Inc.

(Alcoholics Anonymous Publishing, Inc., is now known as Alcoholics Anonymous World Services, Inc.)

## THE TWELVE STEPS OF ALCOHOLICS ANNONYMOUS

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all our defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

# SCHOOL & COMMUNITY PROGRAMS



## THE GREAT FALLS EXPERIENCE

The Care concept came to Great Falls in September, 1981, with a one-week workshop dealing with the problem of alcohol and drug abuse in the school system. This training was conducted by Community Intervention of Minneapolis.

Interested and concerned citizens in cooperation with the Great Falls Public Schools, was instrumental in organizing this workshop, which included six participants from each high school and junior high school, along with other school personnel and interested community members. These trained individuals formed the Community Core Team and CARE Teams in each secondary school.

CARE does not believe that schools cause chemical abuse problems, but they can be one of the most effective places to deal with the problem. Our program is based on the concept that chemical dependency is a primary disease and a family disease. All are affected when chemical abuse and dependency are present.

CARE addresses school alcohol and drug programming at all levels including School Board members, administrators, all staff, students and parents. We believe the most effective program is one that is operational within the school system. With this approach, the school staff and community volunteers become essential in the implementation of the program. Staff involvement is vital in creating the climate necessary to respond effectively to alcohol and drug related problems they are the means by which students receive help.

### PROGRAM GOALS

The primary goals of the school program are:

1. BASIC INTERVENTION: To provide students with appropriate developmental experiences necessary to make responsible life decisions including decisions about chemicals.
2. EARLY INTERVENTION: To identify and intervene on students whose behavior may indicate a chemical use problem before dependency or a crisis occurs.
3. CRISIS INTERVENTION: To provide alternatives and services for students whose chemical related behavior results in a violation of the student code, trouble with the law , a situation requiring the immediate attention of school personnel.
4. STUDENT SUPPORT: To provide support activities for identified students whose lives are affected by chemicals.
5. PROGRAM AWARENESS: To develop among staff, students, parents, and community an awareness of chemical use, abuse, and dependency, as well as to create an understanding of the purposes of prevention, intervention, treatment, and aftercare.
6. STAFF ASSISTANCE: To encourage the staff members to reassess their personal involvement with alcohol and other chemicals and to provide assistance to those who may be experiencing problems associated with substance abuse.

### PROGRAM DEVELOPMENT

Developing and implementing a drug/alcohol education, prevention and intervention program in the school system and community is not an easy or trouble free experience. We expected some difficulties and resistance because the concept of the disease model of chemical dependency is a new one to many individuals and groups. We know this approach to the problem is most effective, and with the continuing support of the community, it is working!

## PROGRAM COMPONENTS

We realize that there are differences between individual schools in our system; consequently the components may be modified to some extent, but the basic concept and approach remains the same.

1. **DISTRICT COORDINATOR:** The district CARE coordinator is responsible for the development, performance, and evaluation of the K-12 Chemical Awareness/Responsive Education programs. This coordinator works cooperatively with School Board, Central Administration, building principals, and building CARE Teams giving assistance as needed, calling meetings, giving advice, providing resources and facilitating exchange of information.
2. **CARE TEAM:** The CARE Team is an in-house resource that works on chemical abuse/dependency problems and prevention programming. This team has the primary responsibility for implementation of the program in the school, for facilitating the education/awareness component, and working directly with staff, students, parents, and community resources.
3. **DISTRICT ADVISORY COMMITTEE:** This committee is the group which maintains and modifies the existing school programs. This committee includes the CARE coordinator, representatives from the four secondary schools, elementary, the Board, central administrators, and the Community Core Team
4. **REFERRAL AND INTERVENTION:** Students enter the programs offered in various ways. Some refer themselves or are referred by parents, peers or the courts. However, the primary referral source is school staff.

In this case, staff members are asked to be aware of behaviors that indicate a problem exists and report those specific behaviors when they occur to the CARE Team. Staff members are not asked to diagnose, just to report specific behaviors or changes in behavior. Other staff in contact with the student may then be contacted to see if a general problem exists. If necessary, parents are then contacted for their input, and an intervention may then be planned. The goal of this process is early intervention, and placement of the student in a program appropriate for his/her needs. In some cases, chemical use is not identified as a reason for problem behaviors and other appropriate referrals are made if necessary.

5. **INSIGHT CLASS:** The insight class is for those students who are found in violation of the student code involving alcohol/drug use or possession, along with those referred by legal authorities or other sources. The Insight Program is an intervention/education program designed to allow students to evaluate their use and its consequences while also providing education in chemical use/abuse for students and their parents.
6. **CONCERNED PERSONS:** This is a voluntary peer support program for students who are concerned about the use of someone close to them.
7. **SUPPORT GROUPS:** The Aftercare Support Group is for those students who have completed a chemical dependency treatment program or are involved in the Alcoholics Anonymous Program. Regular Support Groups are for students who have made a decision not to use chemicals and feel the need for a peer support group.
8. **AWARENESS GROUPS:** This group is for general information on drug and alcohol use, abuse, and dependency with the goal of preventive education at the junior high school level.

Great Falls Public Schools  
School Board Goal No. 6

"Study and develop a program to deal  
with the problem of chemical abuse."

Chemical Awareness/Responsive Education Program in  
Great Falls Public Schools

**Philosophy**

The Board of Trustees recognizes that its primary role of education in the community is to facilitate the education growth of its youth. , One significant condition which impedes educational processes is chemical use, abuse, or dependency. Every effort should be made to deliver the appropriate services to students who experience these problems.

The Great Falls Public Schools believe that chemical dependency is a treatable illness which can be arrested so that the majority of individuals will be returned to healthy, stable, and productive lives. Identification and response to chemical use problems in their early stages will be of benefit to the individual involved and the community as a whole.

**Goals**

Consistent with the School Board goal to "Study and develop a program to deal with the problem of chemical use, abuse, and dependency," in concert with the philosophical statement above, the following goals of the Chemical Awareness/Responsive Education (CARE) program in the Great Falls Public Schools are established:

**I. Basic Prevention**

The objectives of this goal are directed toward providing students with appropriate information and developmental experiences necessary to make responsible life decisions, including decisions about chemicals.

- A. The following prevention curriculum concepts will be integrated into K-12 curriculum areas and special materials will be made available for their instruction.
  - 1. Personal growth
  - 2. Self-assessment
  - 3. Self-esteem
  - 4. Inter-personal relationships
  - 5. Decision making
  - 6. Family communications
  - 7. Value conflict and problem-solving
  - 8. Coping skills
  - 9. Effects of chemical usage
- B. The District will cooperate with the community in their efforts to provide the following:
  - 1. Creative recreational and leisure time programs for students.

2. Information for students and parents on such issues as:

- a. Child development
- b. Family communications
- c. Value conflict and problem-solving
- d. Current drug situation
- e. Early signals of drug usage

3. Opportunities for open-ended parent discussion groups.

C. The District will participate with the Community Core Team in planning and coordinating a community prevention program.

## **II. Early Intervention**

The objectives of this goal are directed toward students whose behavior may indicate a chemical use problem and students who seek help.

A. Procedures will be developed to identify and assist such students.

B. A program will be developed for utilizing peer support groups as the secondary level.

## **III. Crisis Intervention**

The objectives of this goal are directed toward students whose chemical related behavior results in a violation of the student code or precipitates a situation requiring the immediate attention of school personnel.

A. Procedures consistent with School Board policies, the student code and CARE philosophy will be developed to deal with students found to be in violation of school regulations.

1. Disposition of the immediate disciplinary situation by the principal or designee.

2. Response to the chemical related behavior which may include, but is not limited to:

- a. Referral to the building CARE Team
- b. Consultation with parents
- c. Notification of law enforcement agency
- d. Referral for professional chemical use assessment
- e. Transfer to medical treatment

B. Assistance will be provided students who experience a chemically related crisis.

## **IV. Student Support**

The objectives of this goal are directed toward the support which may be provided for identified students whose lives are affected by chemicals.

A. The components of this support system in the schools may include the following:

1. Individual support

2. Group support: (refer to program components, pg. 108)

- a. Awareness
- b. Concerned persons
- c. Support
- d. Insight
- e. Aftercare

B. This support system may also entail the application of community resources and agencies.

## **V. Program Awareness**

The objectives of this goal are directed toward developing among staff, students, parents and community an awareness of chemical use, abuse, and dependency as well as creating an understanding of the purposes of prevention, intervention, treatment and aftercare.

A. Information will be provided staff in the following areas:

- 1. CARE philosophy
- 2. Program components
- 3. Role and responsibility of staff
- 4. Observation and identification skills

B. Information will be provided to students in the following areas:

- 1. Disease concept of chemical dependency
- 2. Family illness associated with chemical dependency
- 3. School programs
- 4. Students support system

C. Information will be provided to parents and community in the following areas:

- 1. CARE philosophy
- 2. Components of the school program
- 3. Role and responsibility of parents and community
- 4. Community/District coordination
- 5. Support groups

## **VI. Staff Assistance**

The objectives of this goal are directed toward encouraging the staff members to reassess their personal involvement with alcohol and other chemicals.

- A. Information and assistance will be provided staff members regarding all aspects of use, abuse, and dependency.
- B. The Great Falls School District recognizes chemical dependency as a treatable illness. the District believes that employees who are so diagnosed should be afforded the same concern and consideration extended to employees with other types of illness.

## **Implementation**

The primary responsibility for the implementation of the Chemical Awareness/Responsive Education program in each secondary school lies with the building principal in cooperation with the building CARE Team and district CARE Coordinator.

## **THE GREAT FALLS COMMUNITY CORE TEAM, INC.**

In the 1982-83 school year, the Great Falls Community Core Team was formed, which was a coalition of civic organizations, government agencies, professionals, concerned citizens and school personnel. The CARE Program Coordinator was the School District's liaison and representative on the Community Core Team. The main goal for the school year was to assist the Schools' CARE Program efforts in the area of parental awareness.

Two major projects contributed greatly towards substance abuse awareness in the general public in these formative years. A Parents' CARE Guide was printed by community donations and distributed to every family with school children in the city of Great Falls. Over 9,700 copies were printed. In 1986 Montana Highway Traffic Safety Division provided 150,000 copies of this guide to Montana families through Montanan's Against Drunk Drivers.

The CARE Coordinator gave presentations and spoke at over twenty PTA's, civic groups and other public meetings in regard to the CARE Program and to solidify public understanding and support of our efforts.

A series of forums were held to investigate legal issues and to promote unified action regarding alcohol and drug problems in the city. A closer relationship between the CARE team programs, school personnel, and legal authorities developed which should contribute greatly towards a cooperative front against the epidemic of adolescent drug and alcohol abuse.

The first Montana Adolescent Drug Abuse Conference was held in Great Falls in 1983. Since that time the Great Falls Community Core Team, Inc. has sponsored two Montanan's Caring for Kids Conferences. The 1988 conference boasted an attendance of 779 persons from across Montana. One half of the proceeds from this conference was given to the new state prevention network, Montana Communities In Action for Drug Free Youth.

Education and awareness of substance abuse issues is an on-going process. There is no "quick fix." A key element for Great Falls has been the continued emphasis on education of students, community, and educators through community support. The close working relationship and cooperation that has developed between the community and the schools in the area of substance abuse is unprecedented.

The Montana Office of Public Instruction has developed a comprehensive guide for drug and alcohol programs called, "Together". The guideline will provide schools and communities with information which may assist you in developing cooperative drug and alcohol programs.

### **ORGANIZING A COMMUNITY EFFORT**

While recognition of the success of the Great Falls efforts can not be discounted, it is also appropriate that we identify the means by which this success has evolved.

Developing and implementing a drug/alcohol education, prevention, and intervention program in the school and community was not an easy or trouble-free experience. We expected some difficulties and resistance because the concept of the disease model of chemical dependency is a new one to many individuals and groups. Some of the stumbling blocks that we encountered were:

#### **1. TURF ISSUES**

Major barriers were with agencies who were defensive of their role. Either they denied that they could improve their systems, or felt that the community was blaming their agency for the problem.

#### **2. DENIAL**

Many community groups and agencies felt that this was not an issue that needed to be dealt with by their organization. Substance abuse issues should be left to "someone else".

### 3. ATTITUDES

The attitude that we just need to get rid of the "bad kids" and if we only had more police, money, time, leadership, interest we could solve this problem.

## KEYS TO SUCCESS

The Great Falls model reflects a comprehensive program that has been integrated into the existing network of school and community services. Each representative group has identified their role in substance abuse prevention efforts. Some of the indicators of their success are:

### 1. NETWORKING

The Great Falls Community Core Team, Inc. continues to be the agency that provides a NETWORKING of community officials, organizations, agencies, and others involved in any areas related to substance abuse. Promoting and assisting in public education and awareness on the issues of substance abuse continues to be their focus.

### 2. OPEN COMMUNICATION

Agencies, organizations, and other interested persons were allowed to bring their concerns to the public through the assistance of the Community Core Team. Through this process the "threat" that was perceived by the involved agencies was gone when they learned that no one was accusing them of not doing their job, but rather, "what can we do to help you to do a better job in areas related to substance abuse issues?"

### 3. COMMUNITY PROGRAMMING

The task of realizing that no one agency, group, organization or individual is large enough to facilitate all of the public education and awareness that must be done. Being able to recognize the limitations of each entity has attributed to our program. The fact is that everybody has to "buy in" and nobody can do it all. Problem solving has been a cooperative effort, a community effort.

### 4. STAYING ON FOCUS

One of the most difficult things to deal with was getting off track. It is very easy to get side tracked into ADULT drug/alcohol issues. Being able to focus specifically on adolescent substance abuse issues was a major factor in the development of the efforts in Great Falls. Some of the things we kept in mind were:

- # It is ILLEGAL for persons under the age of 21 to use, or possess alcohol or drugs .
- # There is supportive data that drugs and alcohol have harmful psychological and physiological effects on young people.
- # We need to provide a chemical-free environment for students in our schools.
- # Responsible use by adolescents is unacceptable. Parents, educators, and others must convey a strong " NO -USE" message to our children.

# STUDENT CODE



REVISED  
JULY 1986

5. Drugs, alcoholic beverages or intoxicants - Students are not to use, be under the influence of or possess drugs, alcoholic beverages or intoxicants at any time while under the supervision, jurisdiction or control of the school. Punishments for violations of this regulation are described below:

NOTE: In lieu of invoking any of the disciplinary procedures listed in this section the principal may extend the offer of participation in an approved substance abuse program. Failure to comply with the requirements of the program would cause the appropriate disciplinary procedures of this code to be enforced.

NOTE: For purposes of this regulation possession of drugs, alcoholic beverages, or intoxicants shall be classified into two categories:

1. Minor - Possessing small amounts obviously intended for personal use.
2. Major - Possessing amounts large enough to indicate intent to sell or supply to others.

a. VIOLATORS WHO HAVE ATTAINED THE AGE OF SIXTEEN AND HAVE COMPLETED THE EIGHTH GRADE

1. Any such student found guilty of using, having used and exhibiting the evidence of use, or in major possession of drugs, alcoholic beverages or intoxicants in school during the regular school day shall be disciplined in the following manner:

The parent or guardian shall be given the options of withdrawing the student from school for the remainder of the current semester with no credit being granted for courses in which the student is currently enrolled. If the parent or guardian does not exercise the option of withdrawing the principal shall instigate expulsion proceedings. (In either event, the school will cooperate with the parent or guardian in searching out alternative educational opportunities for the student.)

Students found guilty of minor possession in school during the school day shall be:

- suspended from school
- readmitted only on probation
- prohibited from taking part for the remainder of the semester in any extracurricular activity in which they are currently participating.  
Additionally, the student shall not be allowed to participate in any subsequent extracurricular activity for a period of 30 school days from the date of the infraction.

A second incident of minor possession during any one school year shall be classified as major possession.

2. Any such student found guilty of violating this regulation outside of the regular school day but at school functions or otherwise while the student is under the control and jurisdiction of the school shall be disciplined in the following manner:

Flagrant Offenses - Students guilty of major possession or who are obviously under the influence of drugs, alcohol or intoxicants so as to be

unruly, disruptive or a menace to their own health and safety or that of others shall be disciplined in the same manner as outlined in section a-1 above. (Parent will be given the option of withdrawal or the principal will instigate expulsion proceedings.)

Incidental Offenses - Students guilty of minor possession or who have used drugs, alcoholic beverages or intoxicants but are not unruly, disruptive or a menace to their own health and safety or that of others shall be disciplined in the same manner as outlined above for minor possession in school during the school day. A second incidental offense by a student during any one school year shall be classified as flagrant.

b. VIOLATORS WHO HAVE NOT ATTAINED THE AGE OF SIXTEEN AND/OR HAVE NOT COMPLETED THE EIGHTH GRADE  
(Infractions in school or at any school function after the school day)

1. Flagrant Offenses - Students guilty of major possession or who are obviously under the influence of drugs, alcohol or intoxicants so as to be unruly, disruptive or a menace to their own health and safety or that of others shall have expulsion proceedings instigated against them by the principal.

2. Incidental Offenses - Students guilty of minor possession or who have used drugs, alcoholic beverages or intoxicants but are not obviously under their influence and who are not unruly, disruptive or a menace to their own health and safety or that of others shall be:

- suspended from school
- readmitted only on probation
- prohibited from taking part for the remainder of the semester in any extracurricular activity in which they are currently participating. Additionally, the students shall not be allowed to participate in any subsequent extracurricular activity for a period of 30 days from the date of the infraction.

A second incidental offense by a student during any one school year shall be classified as flagrant.

c. EXTRA/CO-CURRICULAR MOOD-ALTERING CHEMICAL AND  
TOBACCO USE RULES

The Board of Trustees of the Great Falls Public Schools has established the following minimum rules governing participation in extra/co-curricular\* activities. It is the Board's belief that participation in organized activities can contribute to the all-around development of young men and women and that implementation of these rules will serve the following purposes:

1. To emphasize concern for the safety of students while participating in activities;
2. To diminish the long-term physical and emotional effects of mood-altering chemical\*\* use on the health of students;
3. To provide a chemical-free environment that will encourage healthy development;
4. To promote a sense of order and discipline among students;
5. To confirm and support existing state laws which restrict the use of mood-altering chemicals;
6. To emphasize standards of conduct for those students who through their participation are leaders and role-models for their peers and younger students;
7. To assist students who desire to resist peer pressure which often directs them toward the use of mood-altering chemicals.

It is the position of the Great Falls Public Schools that participation in these activities is a privilege extended to students who are willing to make the commitment to adhere to the following minimum rules:

RULE NO. 1

Students will not use, have in their possession, buy, sell, or give away alcohol, marijuana, or any other substance defined by law as a "controlled substance" or "dangerous drug." Legitimate use of prescription drugs is permitted.

PENALTY

1. Students who violate Rule No. 1 will be prohibited from participation in all extra/co-curricular activities for one calendar year from the date of the rule infraction.

2. In lieu of the one calendar year suspension, the principal may extend the option to the student to participate in an appropriate chemical awareness experience.
3. Upon acceptance of the option, the principal shall waive the one calendar year suspension and impose a thirty (30) day suspension from extra/co-curricular activities from the date of the rule infraction. This period shall include regular school days and any other days which include previously scheduled legitimate practices, competitions, or performances.
4. Students who do not successfully complete the chemical awareness experience would cause the enforcement of the one calendar year suspension from all extra/co-curricular activities.

#### RULE NO. 2

No student participating in extra/co-curricular\* activities shall use tobacco in any form.

#### PENALTY

1. Students who violate Rule No. 2 for the first time will be suspended from participation in all extra/co-curricular\* activities for the duration of two (2) weeks from the date of the rule infraction.
2. Students who violate Rule No. 2 for the second time will be suspended from participation in all extra/co-curricular\* activities for the duration of thirty (30) school days from the date of the rule infraction. This period shall include regular school days and any other days which include previously scheduled legitimate practices, competitions, or performances.

\* Co-curricular activities are those credit-bearing courses that involve activities both inside and outside the classroom setting. Co-curricular, for the purposes of these rules, shall be defined as those activities beyond the classroom and the immediate scope of graded requirements.

6. Weapons and dangerous instruments - Students shall not possess firearms, ice picks, clubs, explosives (including fireworks) or any instrument whose sole or primary purpose is the infliction of bodily injury. Students in elementary and junior high schools shall not possess knives.

## CONCERNED PERSONS

### DEFINITION OF GROUP

Students from troubled families (usually some form of abuse exists) meeting once a week with 2 facilitators.

### PURPOSE OF GROUP

To provide a safe place for students to discuss sensitive frightening problems (within their families).

### OBJECTIVES OF GROUP

1. To help students learn to cope with situation as it exists-
  - a. Al-anon - encourage attendance
  - b. learn to let go of responsibility
2. To help student learn to intervene with family-
  - a. discuss different intervention styles
  - b. discuss roles in families--how to throw a curve--how to inhibit present family system's performance

### HOW GROUPS ARE SET UP

- Tuesday morning first hour/passes sent
- word of mouth
- counselors/teachers/parents/friends refer

### APPROPRIATE CLIENTELE

- Any student, grades 7-12, who is not a member of another group can come (students rotate in and out, but can only attend one group per week in our system.)

### SIZE OF GROUP

- 6-10 people ideal
- 12 tolerable, but some get left out each week
- many when program is new-
- fewer as people learn about options/help/etc.

### MECHANICS OF

- Size - can you afford more than one group? Do you have facilitators?  
- can you handle it from your own point of view?

- Schedule: how much flexibility?  
- how is your own work day organized?  
- how much need for this group vs. other parts of your program?  
- weigh time/cost/needy kids

- Open/closed  
- evaluate at end of quarter  
- new members at quarter breaks  
- people leave at quarter breaks

Credit? come out of class - don't lose credit for class - are responsible for work

Time? 8-9 a.m. once a week

Data collecting: small casual card stating very basic demographics and not that he/she was group member

How referred: above

How re-referred - by us - out to

- family counseling
- Al-anon
- Youth Service Bureau
- AA
- another of our school groups

Contracts: not for this group

Attendance: no formal records kept, but attendance taken for the purpose of checking on student's well-being

Seating: Ask kids to change around only for special reason

### LEADERSHIP STYLES

- 2 facilitators
- informal leadership style
- "non-therapeutic" style
- some teaching - concepts
- some confrontation
- mostly support

### RESPONSIBILITIES OF FACILITATORS

- accept
- support
- teach
- refer
- see one to one
- see parents
- work together apart from group

### ACTIVITIES/EXAMPLES FOR EFFECTIVE GROUPS

- warm-ups      highs/lows of week  
                         best thing that happened  
                         most progressive letting-go  
                         most confrontive/assertive thing  
                         best thing I did for myself  
                         best communication promoted
- group functions      1) active listening skills
  - a. attending behaviors
  - b. body language
  - c. supportive sentences
  - d. relating experiences

- 2) respect for members
  - a. warmth
  - b. empathy            friendliness
  - c. genuineness
  - d. concreteness
  - e. self-disclose
- 3) tasks/chores
  - a. teach
  - b. support
  - c. help
  - d. solve
  - e. learn
  - f. work
  - g. confront/give feedback
- 4) **MAKE FACILITATORS AND GROUP MEMBERS AWARE**

**WARNINGS - HIGH RISK COMMUNICATIONS**

- a. powerful - directing, ordering, commanding, warning, threatening, moralizing, obligating
- b. using information - (we do it all the time)
  - persuading
  - advising
  - questioning
  - sympathizing/reassuring
- c. reduction messages
  - you are wrong
  - you have made a mistake
  - diverting, kidding, teasing, sarcasm, silence - ignoring, guilt

## GOALS OF AFTERCARE AND OTHER SUPPORT GROUPS

(1) Sobriety - life-style free from chemicals

(2) Self-esteem

Self-worth

Self-competence

Self-aware

Self-accepting

Self-responsible

Self-assertive

## MEANS TO ATTAIN AFTERCARE GOALS

(1) Provide environment

Surrender

a) AA Program on a practical, everyday level

way of life

philosophy of life

Honesty with self/others

Responsibility - accountable

Humility - self-acceptance

Spirituality - contact with Higher Power of some sort

Deal with feelings/defenses

## PROBLEM AREAS FOR SUPPORT GROUPS

1) Urge to use

2) Self-esteem

3) Living the AA Program

(1) Urge to use

a) will face urge honestly and seek help from group

b) will repress it

observable negative behaviors follow:

1. breaking contracts (home/aftercare)
2. not calling peers in support group
3. not attending AA (or sporadic)
4. socializing with "junkie" friends
5. sexual-emotional otional involvement
6. absenteeism from group/school
7. tardiness/skipping classes
8. irresponsibility with asslgnments/study
9. not living AA Program (lying, not doing Inventory, etc.)
10. decrease in self-esteem
11. hostile, angry behavior
12. depression - withdrawal from peers  
not sharing in group  
touchiness  
discouragement/self-pity

Suggestions for dealing with above:

1. confront in group - 1:1  
give specific data of observable behavior  
ask direct questions re: urge to use  
emotional involvement  
loneliness, etc.
2. set up "mini-contracts" w/lt kid
3. probation/call in parents
4. discharge from group with recommendations

## (2) Self-esteem

Positive self-esteem essential for ongoing sobriety

Some indications of negative self-esteem:

1. rejection of sincere compliments
2. people-pleasing
3. self down-grading (use of absolutes "never", "always")
4. expressions of feelings of inadequacies, inferiority (jokes about self, hostility toward self)
5. grandiosity

6. down-grading others
7. seductiveness with peers/staff
8. carelessness with physical appearance
9. withdrawal
10. lack of spontaneity
11. suicidal thoughts, expressions

Suggestions for dealing with above:

confront in group - 1:1

encourage sharing of feelings

mini-contracts

meet with parents and kid

if in aftercare, call staff

## OVERVIEW OF THE CARE INSIGHT CLASS FORMAT

Students referred to the CARE Insight classes are provided with a very visible comprehensible structure that specifies expectations for behavior, describes the hoped-for goals of the groups and provides tools to help participants perform a variety of learning activities. Class schedules, procedures for placement in the group, parent and student contract forms, and basic information on drug issues are all expressed clearly and concisely. Anxieties are diminished by knowing what to expect and manipulation is minimized because the process leaves little room for maneuvering. The following paragraphs describe, in barest outline form, the basic contents of the eight Insight Sessions.

### SESSION I. ORIENTATION:

The principle goal of the group segment during this session will be to have each student share the circumstances that resulted in his being in this course. This sharing--accomplished in an "around the circle" structure--develops trust that you are a caring person, not condemning or judging. You want to help each one present to look at his/her use and where it is going, etc.

Rules and regulations are reviewed, expectations clarified, and the need for confidentiality is stressed. Students begin to ventilate their feelings about being referred to the class, and the facilitators do not necessarily confront blatant rationalization and denial in this first session.

### SESSION II. CHEMICAL USE INTRODUCTION:

Time should be devoted to viewing and processing a chemical awareness film. The leader should ask for comments and answer questions posed by students. The students will then provide basic biographical data in the following areas: family; friends; job; hobbies; recreation; money; legal.

The goal is to build trust so that self-disclosure to the group can be accomplished without fear. This is a time to open the subject of drug use and get the students talking. Avoid confrontation at this time.

### SESSION III. DISEASE:

The "Feeling Chart" is used to describe the relationship between feelings, drug use, and the various stages of drug abuse or dependency. It is made clear that alcohol is a drug and that chemical dependency includes the use of all mood-altering chemicals--legal or illegal, prescribed or not prescribed. The way that drugs mask or blunt natural feelings is presented and discussed.

### SESSION IV. FEELINGS AND DEFENSES:

The general goal of this session is to expose students to the role feelings and defenses play in blinding us to honest and realistic problem identification, i. e., delusion/denial. However, because we cannot change what we cannot see, it is not suggested that a "window" be done for individuals in this setting as it has not been very productive in Insight groups.

### SESSION V. FAMILY AND ENABLING:

The goal of this session is to provide information about the family illness and enabling process and to familiarize the student with his role in the family structure.

#### SESSION VI. EXPERIENCING THE PROBLEM:

The following may be invited to speak to the class: a recovering chemical dependent (sometimes a past participant in the Insight classes). It is suggested that the student would come from another school. Professionals from community agencies are also invited and sometimes films are used.

#### SESSION VII. DRUG HISTORY:

The general goal of this session is to confront students with chemical usage by means of a Drug Usage History. The lecture should be geared to teaching students how to do the history honestly without minimizing or exaggerating. It is suggested that the student initiate the drug usage chart from the approximate time he began to use to the present date.

#### SESSION VIII. STUDENT EVALUATION:

The general goal for Session VIII is for continuing confrontation with the student's denial system within the format of a "peer evaluation." Within this process, each student is required to give the group an account of his chemical usage history and an assessment as to where he sees himself relative to a chemical problem. The group is required to respond to the student being evaluated, using the behavioral symptoms they have learned as to where they see the student relative to a chemical problem.

Arrangements will be made at this time with the students and parents for the follow-up or exit interview.

## GENERAL INSIGHT INFORMATION

### GOALS OF INSIGHT

1. Education - Awareness

To give the student opportunity to gain awareness of the harmful consequences of his/her chemical use as well as general information about chemical dependency, family illness, etc.

2. Pre-assessment - Data Gathering

To gain additional information preparing for the exit recommendation to parents, school and/or legal authorities.

3. Parent Involvement and Support

To convince parents of our genuine concern for the welfare of their child and to solicit their support (essential for any subsequent action).

### FORMAT

1. Insight will be conducted as a class with a possible evolution into a group. If student cooperation exists, then group dynamics may be utilized in conducting the necessary confrontation and feedback processes. If not, then the instructor-confronter to student relationship should be followed.

2. The recommended size of the class is three to eight students. Students may be put on "hold" for a short period of time but every effort should be made to work with other schools to begin a "cooperative" Insight groups as soon as possible.

3. There will be eight sessions, up to an hour and thirty minutes in duration. It is recommended that these sessions be scheduled in such a way as to require a commitment from the participant of at least four weeks of sobriety. It is felt that this time is needed to clear away some of the cobwebs associated with heavy use.

If, in the judgement of the facilitator, the student is in obvious need of a professional assessment, the class may be terminated for that participant at any time and the exit interview can be arranged.

4. A curricular guide is provided, and it is recommended that its sequence be followed. It is believed that enough flexibility exists in this curriculum to allow for the individual skills of the facilitators and a variety of techniques.

5. The control of the group should be tight. This is extremely important in situations where several friends or "buddies" are busted together.

6. Total student abstinence is required as per the contract agreement. Failure to maintain abstinence probably should be considered sufficient grounds to go for an assessment.

### MISCELLANEOUS ADVICE TO FACILITATORS

1. When a student is enrolled in Insight, the CARE Team should initiate the collection of past and on-going data by school personnel.

2. Facilitators are advised to evaluate everything you see in the student's behavior.
3. It is an effective procedure to start talking about someone else. The students may be testing to see if you are listening or trust-worthy.
4. Insight group is not a place to get help for yourself. It may be necessary to be disliked by the participants to accomplish your goals.
5. Make a connection between yourself and the student--physical if possible.
6. Be careful of confrontation too early.
7. You may often get "hooked" into a favorite student. Be careful how you handle that issue.
8. Look for one-to-one opportunities where kids can have a chance to "open up."
9. Reach out to resistant kids in a friendly manner.
10. Remember that it often takes 20 minutes or so to get the group going. Be creative in ways to "break the ice."
11. Kids do remember what happens in the class though often they won't admit it. They may use this information someday anyway.
12. Remember that there are more kids worried about what they are doing than they would like the rest of the world to know.
13. You just can't get resolution on a kid's problem during a specific period of classroom or group time. If you are trying to do that, you are trying to do the work of an abstinence support group, of a concerned persons group, or even of a primary treatment program.

Great Falls Public Schools  
Great Falls, Montana

Chemical Awareness / Responsive Education

**INSIGHT PROGRAM CONTRACT**

\_\_\_\_\_  
(School)

\_\_\_\_\_  
(Date)

1. \_\_\_\_\_ hereby agrees to enroll in and regularly attend and participate in  
(Name of Participant)  
the Insight Chemical Awareness Program. The program will consist of a minimum of eight mandatory sessions.
2. In addition, the participant agrees not to use chemicals, including alcohol, through the period of his/her involvement in the program which begins with the signing of this contract. The participant also agrees to attend school as required unless specifically excused by the appropriate authority.
3. The participant further agrees to follow the recommendations of the Insight Group facilitators determined at the end of the eight sessions. When the Insight experience has been concluded, the facilitator, after consultation with the parents, will recommend one of the following courses of action for the participant:
  1. Release from the program with no further participation.
  2. Participation in up to four Support Group meetings.
  3. Completion of a professional chemical dependency assessment.
4. (a) If the participant should use chemicals, including alcohol, during the time he/she is a participant in this program, he/she will be dropped from the program immediately.  
(b) If the participant fails to follow the exit recommendations of the facilitators, he/she will be considered as having failed to complete the Insight Program.
5. (a) Incompletion of the program as per items 4 (a) or 4 (b) will result in the student's status being determined by the appropriate disciplinary procedures in the Student Code (Section XI, B.5.) Further action will be determined by the Principal or his designee.  
(b) Participants referred to Insight by probation, legal, or court authorities who fail to complete the program as per the conditions above will be referred back to the appropriate authority for further action.
6. The Insight class will begin with a parents-student meeting on \_\_\_\_\_  
(Date)  
at \_\_\_\_\_ at \_\_\_\_\_  
(Time) (Place)  
Other significant class data: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Signature of School Representative)

\_\_\_\_\_  
(Signature of Participant)

Great Falls Public Schools  
CARE Program

Dear Assessment Administrator:

This form is being sent as a communication aid to help our schools keep accurate records of students who have been assigned a professional assessment subsequent to completing prescribed Insight sessions. Please complete the sections below and return the form to the appropriate school.

Thank you,

CARE Team Administrator  
Great Falls Public Schools

TO:

\_\_\_\_\_  
(SCHOOL NAME)

\_\_\_\_\_  
(SCHOOL ADDRESS)

\_\_\_\_\_ Has successfully completed a professional assessment  
(Name)  
at \_\_\_\_\_ on \_\_\_\_\_  
(Name of Facility) (Date)

\_\_\_\_\_  
(Signature of Assessment Facilitator)

\_\_\_\_\_  
(Date)

# **STUDENT SUPPORT GROUPS**



## THE GROUP



### Purpose:

- 1) To increase interpersonal learning of strengths and weaknesses.
- 2) To gain greater understanding of one's defenses and how they impede self-discovery.
- 3) To gain further access to the "feeling being" in one's self.
- 4) To explore acceptance of self both the positive and the fallible aspects.
- 5) To provide a forum for one to undergo a corrective emotional experience and understand its implications.
- 6) To provide support and explore alternative forms of social relations.

## II. Johari Window

Group is an attempt to have someone perceive what is in need of change. To gain knowledge of what needs to be identified and how the group process aids in this discovery we turn to the "Johari Window."

		Self	
O t h e r s	1	Public	3 Secret
	2 Blind	4 Subconscious	

The four panes are representative of the total self and can be used to clarify the function of feedback and self-disclosure.

**Pane 1** is the public self; that information which we are aware of and are willing to share with others.

**Pane 2** is the private self; that information which we are aware of but choose to keep secret from others.

**Pane 3** is the blind self; that information which we are not aware of but is known and seen by others.

**Pane 4** is the unconscious self; that information which is not known or accessible to self or others.

In group sessions change takes place via others sharing their perceptions (feedback) of information from Pane 3, and increased self-disclosure (revealing information from Pane 2). When one gains insights via the group process into Pane 4, Pane 1 increases in size and subsequently the others decrease as follows:

1 Public		3 Secret
2 Blind	4 Subconscious	

### III. Techniques for Understanding

- A) **Self-Disclosure:** The revealing of one's private self to other group members. This aspect of group is greatly feared and valued by all group members. There is need to understand that self-disclosure involves risk. The degree of risk depends on several factors:

- 1) fear of rejection
- 2) the nature of the material disclosed
- 3) whether the receiver will receive the information as it is intended and
- 4) how the receiver reacts to the information disclosed.

Self-disclosure will increase as a member feels good about being accepted and understood after disclosing intimate material. Self-disclosure is necessary to form meaningful relationships and therefore necessary to the success of the group.

## THE GROUP

- B) **Confrontation:** The revealing and providing feedback to others of how we see them. It is NOT ATTACKING SOMEONE! Confrontation is most useful and effective when combined with concern and specific behavior or data. There is also risk in honest confrontation, fear that the receiver will
- 1) reject or distort the confronter's feedback
  - 2) reject and become angry with the confronter
  - 3) increase his intimacy with the confronter
  - 4) reciprocate with honest confrontation.

### IV. Feelings and Defenses

- A) **Feelings:** At the risk of sounding elementary, feelings are natural and okay to have. Simply stated "feelings are irrational states of being which in themselves are not good or bad." However, the expression of these feelings can be appropriate or inappropriate. Basic states of feelings are anger, sadness, happiness, fear, shame and guilt.
- B) **Defenses:** Defenses are basic methods used to protect against real or imagined threats to the self. It should be realized that defenses are both natural and adaptive. It is when these defenses block access to feelings which are important to interpersonal learning or when they begin to interfere with one's daily functioning that they need to be identified. Once identified and once a discovery about one's self is established then the option for genuine change exists.

### AWARENESS — ACCEPTANCE — OPTION FOR CHANGE

- 1) Awareness of emotion and/or values leads to the ability to make decisions about behavior. When we can make choices about behavior, we can experience healing.
- 2) Without awareness feelings/values are blocked and are acted on unconsciously. In this way our defenses victimize us. We have lost touch with our ability to choose our behaviors.

The following page is a list of the 12 basic defenses.

## DEFENSES

1. DENIAL—that which one does not want to see or acknowledge ceases to exist; based on wish fulfillment to alter reality.

Example: Someone in obvious emotional difficulty and crying heavily, but denying that they are unhappy. (Never able to admit unhappiness).

2. REPRESSION—similar to denial in that what we want to stop will *eventually* cease to exist.

Example: Whereas in number one the person was never able to admit their feelings it differs with repression. Here the person is able to admit their feelings at the time but will not be able to recall them later. (i.e. 15 minutes after the person cannot recall being unhappy.)

3. INTROJECTION—the symbolic “taking in” (eating) of others, representing a positive interest, however, “swallowing” the object subsequently destroys it.

Example: Popeye is magically rewarded with strength by eating the spinach, but the spinach is “all gone”.

4. IDENTIFICATION—personal identity diffuses by identification with others.

Example: to avoid being excluded from a group or rejected by a person one changes their behavior so that it imitates the significant other.

5. PROJECTION—attributing one’s affect feelings to someone else.

Example: If I don’t like you, but that is too threatening for me, then I will believe “you” don’t like me.

6. DISPLACEMENT—attributing one’s affect/feelings to another cause, instead of the original source.

Example: I’m angry with my parent, but fear their disapproval thus I become angry with my teacher.

7. REACTION FORMATION—taking the opposite side of one’s true affect/feelings.

Example: If I’m angry with you but find it too threatening, I will be pleased and happy with you.

8. UNDOING—something positive is done, actually or by magic, which is the opposite of what was done before.

Example: Someone saying, “You’re an idiot. Not really, I was just kidding.”

9. ISOLATION—Marked by separation and compartmentalized thinking; separating the appropriate feeling from the actual event.

Example: Recall of an emotional event in detail, but feel no emotion about. (i.e., girl who dryly reports being raped.)

10. REGRESSION—Giving up something which is painful and going backwards to an earlier stage (behaviorally or emotionally).

Example: An adult trying to act like a teen because growing old is too devastating.

11. INTELLECTUALIZATION—Using intellectual statements to explain feelings, reactions and behavior with no affect noted.

Example: "My teacher doesn't like me because I'm too much of a challenge for his competency." (Instead of acknowledging being hurt by being rejected.)

12. RATIONALIZATION—Explaining away one's behavior and justifying such by external circumstances.

Example: "I didn't want to quit my job, but the bosses were unfair, the pay was poor, etc." Instead of acknowledging you were perhaps fearful of the job.)

## THEORY AND GOALS OF GROWTH GROUP

by Robert F. Premer, M.D.

"The warm, subjective human encounter of two persons is more effective in facilitating change than is the most precise set of techniques growing out of learning theory or operant conditioning." Carl Rogers

For the purposes of our Growth Groups, the following seems to be an adequate theory. This theory and the methods for growth that have emerged from it have proven successful in our experience and seem to be substantiated in the scientific literature.

### THEORY OF GROWTH

That all personal growth, as well as damage, comes through our relations with the significant others in our lives. (This theory disregards genetic influences that we know can be very important, but we can do very little about them in Growth Group but accept them.)

### THE PROBLEM

The problem is poor human relations and irresponsible behavior, largely due to abuse of mood changing chemicals.

### THE BASIS OF GROWTH GROUP

First we must become chemically free. Then we believe that emotional, behavioral, psychological, and spiritual growth can take place by encountering you and other members in the Growth Group as real, empathetic, and genuine human beings who show unconditional positive regard for the other members of the group.

Change is facilitated by attitudes which exist in the leader and the Growth Group, rather than by any theories or elaborate techniques.

- A. Encountering in the Growth Group is the method.
- B. Growth is the desired outcome.
- C. Trained amateurs do as well as professionals as leaders.
- D. To be real means to be in touch with your feelings and to trust yourself as a feeling human being.
- E. To be genuine means the ability to communicate your feelings in a believable way that is most acceptable by that individual (four-letter words turn some people off and might hit the mark with other - in general, swearing is discouraged in our Growth Groups).
- F. To be empathetic is being able to put yourself right into another person's shoes; to know exactly how someone else is perceiving a given situation and how they feel about it.
- G. Unconditional positive regard means we must believe in a member's ability to grow or our methods will not work. If you become disgusted with a member and cannot form a trusting relationship, growth will not take place. It is the relationship that is important, not the techniques.

---

## GUIDES FOR RESPONSIBLE SELF-GROWTH

### 1. BECOME AWARE OF YOURSELF

Ultimately, this includes not just being aware of your physical and mental self, but your emotions as well - even aware of your unconscious drives and motivations. Ask yourself the question, "What am I doing? Is it getting me what I want? If not, what is it getting me?"

2. TAKE RESPONSIBILITY FOR YOUR SITUATION

This means that you must be willing to accept responsibility for the results of your behavior. In other words, if you are not getting what you want, it is probably your fault, and only through your action (i.e., by experimenting with different behaviors) are you likely to bring about different results.

3. LOOK AT THE POSSIBLE ALTERNATIVES

What other choices of behavior are open to you? What tentative models are more consistent with your values? What are the likely consequences of being more like this or that or of trying on a certain new behavior? What is the best thing that could happen? What is the worst thing that could happen?

4. CHOOSE AMONG THE ALTERNATIVES

What general things do you really want to work on? What qualities do you want to manifest in your life? What specific behaviors do you want to try out for the next week, month, etc.? (Note the use of the word want rather than should. True personal growth happens when a person follows his immediate striving for a greater ideal, not when he feels driven by "shoulds.") Decide on a behavior to try out.

5. AFFIRM YOUR DECISION

Using the power of fantasy and belief, imagine yourself manifesting this new behavior in a variety of situations. Place a poster or a motto reinforcing your chosen quality or behavior in a permanent place where you will see it a lot (for example, on the refrigerator, next to the bathroom mirror, over your desk, etc.). Develop and meditate upon a seed thought which reinforces your new attitude or behavior. (Examples of seed thoughts are "I can become whatever I want to." "I don't have to please everyone all the time." "I can stand up for what I believe in rather than going along with the crowd.")

6. DEVELOP A PLAN OF ACTION

Map out in detail the specific steps of your plan in the order you will need to take them.

7. ACT! NOW!

At some point you must actually take the risk of "trying on" the new behavior.

8. EVALUATE THE OUTCOME

Evaluate the results of your attempts. What happened? How did you feel during and afterward? Were the results worth the risk? If you are willing to add this new behavior or attitude to your repertoire, you have become expanded - there is a greater range.

## OBSERVER CHECKLIST OF LEADER BEHAVIOR

- A. **EVOCATIVE BEHAVIOR:** Leader interventions designed to get the person or group to respond.
1. Inviting \_\_\_\_\_
  2. Questioning \_\_\_\_\_
  3. Confronting \_\_\_\_\_
  4. Exhortation \_\_\_\_\_
- B. **COGNITIVE LEARNING:** Leader intervention to get person or group to look at something.
1. Explaining, interpreting \_\_\_\_\_
  2. Inviting members to seek feedback \_\_\_\_\_
  3. Providing concepts for how to understand (meaning of body posture, tone of voice, interpersonal games). \_\_\_\_\_
- C. **SUPPORT:**
1. Protecting \_\_\_\_\_
  2. Support, affirmation \_\_\_\_\_
  3. Offering friendship, love, affection \_\_\_\_\_
- D. **MANAGEMENT:** Leader behavior directed toward how people are working relating to one another and function of group.
1. Focusing (drawing attention to something that happens to the group or what someone said or did) \_\_\_\_\_
  2. Decision making \_\_\_\_\_
  3. Suggesting procedure for the group or a person \_\_\_\_\_
- E. **USE OF SELF:** Leader behavior in which the primary thing is the focus on self to accomplish some learning purpose.
1. Reveals own "Here and Now" feelings \_\_\_\_\_
  2. Reveals own personal values and beliefs \_\_\_\_\_
  3. Participates as a member of the group \_\_\_\_\_

Genuine	_____	Artificial	_____
Lenient	_____	Strict	_____
Shows Feelings	_____	Hides Feelings	_____
Enthusiastic	_____	Unenthusiastic	_____
Influential	_____	Uninfluential	_____
Relaxed	_____	Tense	_____
Sympathetic	_____	Unsympathetic	_____
Outspoken	_____	Reserved	_____
Directive	_____	Non-directive	_____
Constructive	_____	Destructive	_____
Unworried	_____	Anxious	_____
Thorough	_____	Careless	_____
Active	_____	Passive	_____

## **BARRIERS THAT MAY BLOCK COMMUNICATION IN GROUP**

1. Directing, Ordering, Commanding
2. Warning, Threatening, Admonishing
3. Moralizing, Preaching, Obliging
4. Persuading with Logic, Arguing, Instructing, Lecturing
5. Advising, Recommending, Providing Answers or Solutions
6. Evaluating, Judging Negatively, Disapproving, Blaming, Name-calling
7. Praising, Judging or Evaluating Positively, Approving
8. Supporting, Reassuring, Excusing, Sympathizing
9. Diagnosing, Psychoanalyzing, Interpreting, Reading - in, Offering Insights
10. Questioning, Probing, Cross - examining, Prying, Interrogating
11. Diverting, Avoiding, By-passing, Digressing, Shifting
12. Kidding, Teasing, Making light of , Joking, Sarcasm

# THE GROUP

I hate you, fear you, threaten to leave you.  
I plan and plot how I can deceive you.  
And then I feel myself drawn back again.  
And so I mingle in . . .  
Edging into your circle of fellowship  
As we feel each other's psychic pulse  
I give my little cry for help.  
It is disguised sometimes in laughter.  
Trailing close behind some wall of words.  
It is often soft and low and seemingly  
With little interest, thought, or feeling dropped.  
And then I pray, even in my fear.  
I pray against my outward wishes that you heard.  
I pray to God you felt the tremor in the word.  
And usually you do.  
And with slow motions and earnest voice  
You stab with deft precision where I hurt.  
Sometimes you stab around the circle  
And I marvel that I did not let the feeling show  
With my emotions festered so.  
I hurt, and I curse you for the moment then.  
But when the poison's gone and pressure wanes,  
I thank God that you were there  
And that you heard and cared enough for me  
To lance the inner boils and help to make me free.

Glenn A. Koch

Chaplain/Counselor, U.S. Air Force, David-Monthan AFB, Arizona

## DEFENSE MECHANISM IN GROUPS

Growth through group experience is often painful. Despite the fact that most of us choose to take part in group activities to learn more about ourselves, experiment with new behaviors, and improve interpersonal skills, it can be expected that we will resist the process because it is frightening and demanding. The pressures to engage in self-disclosure, intimacy, and confrontation may bring about changes in our conceptual framework, precipitate anxiety, shame, guilt and other uncomfortable feelings. There is a natural tendency to avoid such feelings, and each of us has developed his own preferred means. Avoidance behavior or defense mechanisms are usually well-ingrained and unconscious. Each of us brings his own particular set to the group. Because these defenses interfere with individual and group growth, it is important to recognize and deal with them effectively.

Although all defenses are essentially evasive in nature, such maneuvers may be categorized by whether the individual moves toward (fight) or away from (flight) the source of conflict or chooses to manipulate other group members (pairing).

A. Fight Defenses These are based on the premise that "the best defense is a good offense."

1. Competition with the facilitator: The person who struggles to control the group or "out-do" the trainer may be attempting to prove his group prowess in order to avoid dealing with his own behavior.
2. Cynicism: This may be manifested by frequent challenging of the group contract and goals, skeptical questioning of genuine behavior, and attacks on stronger, threatening members.
3. Interrogation: A barrage of proving questions keeps one on the defensive. An individual who habitually cross-examines others in the group under the guise of "gaining helpful information and understanding" may be fighting to keep the spotlight safely away from himself.

B. Flight Defenses These are the most frequently used means of avoiding honest, feeling-level involvement in group process:

1. Intellectualization (head trips, dime store psychology): These are processes by which an individual deals with his emotions in an objective, diagnostic or interpretative manner so that he never comes to grips with his gut-level feelings; e.g., "I guess I'm angry with you because you remind me of my older sister." Even entire groups may resort to becoming involved in apparently worthwhile but evasive, drawn-out discussions of social and general behavior issues.
2. Generalization: Closely related is the tendency to make general, impersonal statements about group behavior instead of applying them directly to self or specific participants. For example, a tense person states: "People can really get anxious when there are long silences" when he really means "I am very uptight with this silence."
3. Projection: Here the individual attributes to others, traits which are unacceptable in himself; e.g., someone competing for attention in the group may attack another person for using more than his share of the group's time.
4. Rationalization: This is an attempt to justify maladaptive behavior by substituting "good" reasons for real ones; e.g., "I am not getting very much out of this group because there are not enough people my age, and I just can't relate with the group members," or "if only I were in that other group, things would be better."

5. **Withdrawal:** This defense may vary in intensity from boredom to actual physical removal on oneself from the group. Consistently silent persons may be passive learners but are not growing interpersonally. Groups which fall silent frequently, especially after dramatic moments, are also in flight. The tendency to deal with past interaction issues instead of the "here and now" is another form of withdrawal.
- C. **Group Manipulation Defenses** Participants frequently maneuver other members into specific kinds of relationships in order to protect themselves from deeper involvement or confrontation.
1. **Paring:** Members seek out one or two supporters and form an emotional sub-group alliance in which they protect and support each other.
  2. **"Red Crossing":** This may occur both within and outside sub-groups. In conflict or confrontation situations, the member mediates for or defends the person under fire. The assumed contract is "Let's keep it safe; I'll come to your aid if you come to mine."
  3. **Focusing on One:** An entire group may find itself spending an excessive amount of time and energy on one individual. By keeping the spotlight on a single person for an extended time period, the opportunities increase for large numbers of participants to fall silent or keep the action away from themselves.

Even when recognized, the task of dealing with each of these defenses is not an easy one. Occasionally, an appropriate non-verbal or other structured exercise can be an effective means of uncovering evaded feelings. However, there are no simple, consistently effective methods or responses for dealing with these defenses. Generally, once the evasive maneuver is recognized, the person(s) involved should be confronted, keeping in mind the tenets for effective feedback. As an atmosphere of mutual trust is established, the group participants are apt to lower their defenses and risk experimenting with new growth producing behaviors.

## CHARACTERISTICS OF EFFECTIVE FEEDBACK

Feedback is communication to a group or person regarding the effect the group or that person's behavior has on another person. These effects may involve perceptions, feelings, reactions, etc. Feedback is not criticism! Criticism is evaluative; feedback is descriptive. Feedback provides the individual with information - information he can use in performing his own evaluation. If the individual is not being evaluated, he is not as likely to react defensively. Other characteristics of feedback are:

1. It is specific rather than general. To be told that one is "dominating" will probably not be as useful as to be told "just now when we were deciding the issue, you did not listen to what others said and I felt I had to agree with your arguments or face attack from you."
2. It is focused on behavior rather than on the person. It is important that we refer to what a person does rather than to what we think or imagine he is. Thus we might say that a person "talked more than anyone else in this meeting" rather than that he "is a loudmouth."
3. It takes into account the needs of the receiver of the feedback. Feedback can be destructive when it serves only our own needs and fails to consider the needs of the person on the receiving end. It should be given to help, not to hurt.
4. It is directed toward behavior which the receiver can do something about. Frustration is only increased when a person is reminded of some shortcomings over which he has no control or a physical characteristic which he can do nothing about.
5. It is solicited, rather than imposed. Feedback is most useful when the receiver himself has formulated the kind of question that those observing him can answer.
6. It involves the sharing of ideas and information rather than giving advice. By sharing ideas and information, we leave a person free to decide for himself, in accordance with his own goals and needs. When we give advice, we tell him what to do, and to some degree take away his freedom to decide for himself.
7. It is well-timed.
8. It involves the amount of information the receiver can use rather than the amount we would like to give.
9. It concerns what is said or done, or how it is said or done, not why!
10. It is checked to insure clear communication.



## BODY LANGUAGE AND NON-VERBAL COMMUNICATION IS:

shaking hands  
your posture  
facial expressions  
your appearance  
voice tone  
hair style  
clothes  
gestures  
expression in your eyes  
smile  
how close you stand to others  
how you listen  
your confidence  
your breathing  
your manners  
your mannerisms  
the way you move  
the way you stand  
how you touch other people

These aspects affect your relationship with other people, often without you and them realizing it.  
Sense Relaxation, Bernard Gunter, 1968, p. 90.

Each of us has our own particular ways of affirming or denying what we say or feel through our body language. After a little observation and practice, it is possible to pick up on what other people are really saying. If a person's body is tense, they are often upset or tense about something. If they physically withdraw from the group, i.e., lean way back in their chair, withdrawn into a corner, etc., they are bored or uncomfortable with what is happening.

Exercise: Pair up with someone and sit down facing each other. Deliberately cancel everything you say with a non-verbal disqualification.

## AVOIDANCE OF THERAPY SITUATIONS IN GROUP

It seems to be a major concern of support group facilitators and would-be facilitators that the group carries with it an inherent risk of going "too deep", of some one freaking out emotionally while in the group and the facilitator not being able to help. From time to time, a person will come to the group in a state of stress and because of the trust atmosphere, share his stress. This type of situation cannot be avoided, it is part of the group trust atmosphere. The key is the response of the group to it. Since a support group is a support group, that is what you should provide. Simple listening will provide support. Reassurance, warmth, touching are all good methods. If you feel he really needs counseling, you should attempt to refer him to someone who can help. Know the community resources to refer him to and be honest with him as to why you feel help is needed. Needless to say, referring in most circumstances should not be done before the entire group, but privately. In a stress situation, these are things you should avoid doing: do not make inquiries into the source of the problem, i.e. don't try to make it deeper than it already is. Do not try to solve the problem or be directional. He is looking for support; give him that, not therapy. One general statement on setting up a group contract may alleviate some of this particular problem. Make it clear from the start that the group is not a therapy group and that you are not equipped to handle that type of interchange. If the group wishes to loosen this rule at a later date, they can. Also, try to keep the focus of discussion on the group or subject, not on the deep personal problems of the members. As the group develops, the members will develop a sense of what they can adequately

handle in the group, and the norms can be changed to meet the current needs of group members.

### **KEEPING ON THE SUBJECT**

Every group facilitator has their own way of accomplishing this according to his own facilitating style and the composition of the group. What follows is a simple series of suggestions on how you can go about doing it:

1. Simply break in and relate what they are talking about back to a larger picture.
2. If the group is so totally off the subject that going back to it would be fruitless, take risk and talk about something that is bothering you and that you feel you need support with. It will encourage others to do the same.
3. Refer back to the last comment made on the subject.
4. Get up to get a cup of coffee, go to the john, etc. This type of act is very suggestive, and when everyone is settled again, a new subject can be started or you can begin by making a statement about the old one, ignoring what was off the subject.
5. The old standby, "Hey! I think we're really off the subject here."

One thing to remember is that excursions off the subject in a support group frequently lead to something very valuable. Use discretion and your experience to guide you as to when you should attempt to stop it and when you should let it go. Often, a quiet member who is not usually taking risks will use these times to reveal something of herself to the group. A support group is usually pretty unstructured, and an iron hand from the facilitator will not be appreciated.

### **RISK TAKING**

The willingness to take risks in group is directly tied to the level of trust within the group. So at the earlier stages, do not expect heavier risks. Some people have a relatively easy time taking risks. For others, there must be a very high level of group trust.

The facilitator can encourage others to take risks by being willing to take them himself. If he finds that the members of the group are not taking risks, the group should discuss this to determine why and to try to correct the situation.

### **DRAWING OUT**

It is important to establish in the beginning of the group that the facilitator and all the group members have respect for one another as persons. Therefore, what each member has to contribute is important to the group. This may sound obvious, but if any group member were to have the idea that his contributions were not valid because other group members were more educated or eloquent, the entire group would lose out. If this is well established, it may give less confident members the assurance that they are valued by the group. Of course, this also implies that the group must be careful to keep under control the over-intellectualizer who can be pretty overwhelming.

In the event that the facilitator senses that there is less regard within the group for a particular member or members, it is within his role to convey his own acceptance, and the attitude that to him, this is an important person, whether or not he agrees with what this person has to say. Often other group members will take their cue from the facilitator's accepting attitude.

There are some concrete techniques that can be utilized in drawing out the shy or reticent person. These fall into two categories: the verbal and nonverbal approaches.

### Verbal Approaches

1. Greetings Simple social pleasantries at the beginning of the group before the actual meeting starts. Fairly obvious, but if each person is included, it conveys the attitude that each member is wanted and welcome. Into this falls the introduction done at the first meeting, which should have a requirement of some kind, a non-threatening statement about who each person sees himself to be.

2. Sharing perceptions Verbalize what you perceive. Observation is the foundation on which communication is built. You may present your observations of what you see the person as saying or doing for their validation. It's not within the support group's focus to challenge the person's way of testing reality, but you still may help the person to clearly get across to the group what she wants to express. For example, if you sense a member having difficulty getting her point across, you could say something like, "I hear you saying that you were afraid to try this. Is that what you meant to say?" Also, you can pick up on incomplete feelings you hear expressed, and encourage the person that it's all right to share this feeling with the group.

3. Including When an issue is under discussion, turn to the reticent member and ask him how he feels about it. This takes a little practice to pull off without seeming artificial, but it becomes comfortable before long. The shy member who you encourage this way may be very grateful for an opportunity he was unable to make for himself. Also, topics can be set up in such a way that discussion goes around the circle, giving the shy one an opportunity to have the floor all to herself.

### Non-Verbal Approaches

1. Active listening So important that this is a whole category in itself.

2. Facial expressions and body movement Conveys a wish to communicate. It's another subject which warrants a whole study of its own.

3. Use of touch Through touch we can convey concern, gentleness, sympathy, respect. It is important to remember that touch has these attributed only when both people are comfortable with it. Otherwise, it serves only to make the parties involved more distant from one another. People give each other clues as to when they're ready to be touched. As group cohesiveness grows, these clues can be sensed.

4. Use of silence Times will arise when no one is speaking, but you are communicating. Silence in itself often encourages the shy one to verbalize if it is an interested, expectant silence. It gives the person the opportunity to collect and organize his thoughts, to think through a point, or to consider introducing a topic of greater concern to him than the one being discussed. It allows a person to discover that he can be accepted even though he is silent, that even though he is shy and quiet, he has worth and is respected by another group of people.

These are just a few techniques that can be used to draw out group members. As cohesiveness within the group grows, it seems that people become accepting of each other's idiosyncrasies. The quiet person seems to be comfortable with his quietness, and the other group members seem to wait with interest to hear what he wants to say. In other words, all the people, as they get into themselves as people, seem to begin to appreciate the fine differences that makes each of them a unique individual.

## **ACTIVE LISTENING**

Rules and guidelines in developing the skill of active listening.

1. Notice especially the attitude and feeling involved in the message.
2. Tell the person, as exactly as you can, what you heard him/her say and the feelings and attitudes involved.
3. Try to use words different from what the sender used without changing his meaning.

4. Do not add or subtract from the sender's message.
5. Do not respond to his message by sending a message of your own, such as evaluating, giving opinions, using logic, analyzing, questioning, etc.
6. One way to start learning to respond to a sender's message is by beginning your sentence in one of the following ways: "you feel the . . .", "What I hear you saying is . . .", "What I think you said is. . .", "You're (name the feeling) . . .".
7. As a safe general rule, simply paraphrase what the other person has said or is feeling. To do this best, put yourself in the other person's shoes and TRY to understand what he is feeling or what his message means.

**Basic attitudes that must be present when a person is using active listening effectively.**

1. You must WANT to hear what the other person has to say.
2. You must genuinely want to be helpful to him with his particular problem.
3. You must genuinely be able to accept his feelings, whatever they may be or however different they may be from your own feelings or from the feelings you think he should feel.
4. You must have a deep feeling of trust in the person's capacity to handle his feelings, to work through them, and to find solutions to his problems.
5. You must appreciate that feelings are transitory, not permanent.
6. You must be able to see the person as someone separate from you -- a unique person not joined to you, a separate individual having been given his own life and his own identity.

## LEVELING

To respond openly and honestly to being confronted is to level. We level when we take the risk of being known by spontaneously reporting our feelings. For example: We level when we let someone know we are afraid or that we are angry.

Using these feelings as an example of leveling is probably useful for two reasons. Anger, bottled up (resentment), or fear that is kept hidden (anxiety) seem to lead to more relapses than any other feelings. Also, anger and fear, along with affection, are usually the hardest feelings for us to report. Frequently, people make the mistake of assuming that the purpose of the group is to make someone angry. Anger is an important feeling - but it is only one feeling among many that we want to discover and level with.

If, instead of leveling, we respond without naming a feeling, we are hiding. The ways we hide our feelings are many, and we call them defenses. Each defense serves to avoid naming the feelings we are now experiencing. This prevents us from being known. One of the most helpful things that the group can do is to help a member identify his defenses. Most defenses in alcoholics cluster around rationalization, denial, and projection regarding their disease and its consequences. There are many other defenses, however, that we all use to protect our self esteem and hide our feelings. Certain defenses tend to cover up certain feelings:

Justifying and explaining, covering guilt,  
Laughter and joking covering fear,  
Defiance and silence covering anger.

These defenses can, of course, hide all the other feelings as well. There is no one-to-one relationship between a certain defense and a certain feeling, although there are trends in that direction.

Study the following list. There is a good deal of overlapping. Prepare a list of your own defenses. What are your favorite defenses? Be ready to identify them and other defenses in members of your group. Defenses which we all use to some extent are:

Rationalizing	Minimizing
Denial	Evading, Dodging
Projection	Defiance
Justifying	Attacking, Aggression
Blaming, Accusing	Withdrawing
Judging, Moralizing	Silence
Intellectualizing	Laughing
Analyzing	Verbalizing, Talking
Explaining	Shouting, Intimidating
Theorizing	Threatening
Generalizing	Frowning
Quibbling, Equivocating	Glaring
Debating, Arguing	Staring
Sparring	Joking
Questioning, Interrogating	Grinning, Smiling
Switching	Protecting
Denying	Agreeing
Smug, Superior, Arrogant	Complying

## HOW TO GET A MEMBER STARTED IN GROUP ON A FEELING LEVEL

Leveling with the feeling of fear for a starter and discover how that makes you feel. Most people feel some fear in group. You might start talking about your fear of leveling or being confronted. You'll probably find, as others have, that when you report a feeling we don't begin now to risk being genuine and self-revealing, when will we ever really do it?

## REVIEW OF THE GROWTH GROUP PROCESS

Remember the Growth Group Process has three steps:

1. Recognize the feeling and name it.
2. Discovery of the defenses that prevent the expression of that feeling.
3. Understanding what that feeling means to you and accept the feeling as your own.

By working through the process, we obtain a better understanding of ourselves, and are then able to

1. Behave in a more responsible way.
2. To improve our interpersonal relationships.
3. To lead a more balanced life.

We call this growth and that's what Growth Group is all about in the final analysis

The role of the leader is to facilitate this process.

Terrence E. Troy  
Robert F. Premer, M.D.  
Copyright February 21, 1979

## CONFRONTATION

Confrontation (concerned description) is defined as: Presenting a person with himself by describing how I see him. Confrontation is most useful when spoken with concern and accompanied with examples of the confronted behavior or Data.

Some examples of confrontation follow. Note the emphasis on feelings and defenses:

"You seem self-centered to me because you only talk about yourself ...."

"You seem hostile because of the sarcastic answers you give...."

"Your voice sounds so sad I see you feeling sorry for yourself...."

"Your face is so red you seem very angry...."

"John, each time Joe confronts you, you explain yourself instead of leveling with him. How do you feel about what Joe told you?"

"John, you go into a long silence after each confrontation instead of leveling. How are you feeling when you withdraw in silence?"

By identifying the defenses we are using, as in the last examples, we have a better chance of letting down the defensive wall that is locking others out and keeping us prisoners. This blocks us getting close to others as well as our getting closer to ourselves. Coming to recognize these blocks to self-recognition (defenses) may enable us to look behind them to discover the feelings concealed from view. An example of this might be recognizing the long explanations that hide feelings of inadequacy and guilt. Since defenses and attitudinal postures (character defects) do hide us from ourselves, as well as others, it is important to identify them. A lot of this is new, so while you are getting used to it, just TRUST YOUR IMPULSES. Spontaneous expressions tend to be much more honest. IT IS MORE HELPFUL TO BE REAL THAN TO BE RIGHT!

Most of us tend to think we already know ourselves and are afraid of looking badly, so it is hard for us to take the risk of being real, genuine, empathetic, and to level with our feelings. But what have we really got to lose? Remember how unsuccessful our previous attempts to change have been? Since we can't change something until we really see it and accept its existence, we should ask ourselves, "Do I really accept something if I keep it a secret?" In Growth Group we say, "We are as sick as our secrets." To know ourselves, we must disclose ourselves. Risking openness is the key. When you are tempted to withdraw into silence, remember that we are all in the same boat, and a common feeling of everyone when he is introduced to group is fear.

Frequently, in place of confronting a person with some data that we have observed (what they said, how they look, or sound, etc.), we make the mistake of shrewd guessing or of asking questions and giving advice:

"I bet you fight a lot with your wife...."

"Did your parents raise you very strictly?...."

A shrewd guess or a question is not confrontation. It is playing amateur psychiatrist.

The other mistake is advice giving in place of confronting:

"Don't let people walk all over you so much...."

To state this as confrontation would be:

"You seem like a doormat the way you let people walk all over you ...."

This way we are not playing God by advising, but we are letting the person see himself from another point of view and trusting him to seek advice if he wants it.

Avoid playing amateur psychiatrist and God!

Confrontation is a concerned description of what we have observed in the person we are confronting. Guesses, advice, or discussions about something we have not witnessed is not confrontation. In a sense, when we confront, we hold up a mirror to let another person know how he appears to us in the "here and now". We do it with concern in a supportive environment.

We are most useful as confronters when we are not so much trying to change another person as we are trying to help him see himself more accurately. Change, if it comes, comes later when the person accepts himself as he really is, becomes willing to change, and chooses to enlist the spiritual help that the 6th and 7th Steps of the Alcoholics Anonymous Program describes.

Let me illustrate it this way: Picture a gardener preparing a proper environment within the soil so that the seeds he plants may receive the gift of growth from a Power greater than himself. Imagine a physician cleaning a wound to provide an environment to receive the gift of healing. The change we are all seeking might be more correctly labeled healing or growth and, while it is largely a gift of a Power greater than ourselves, the necessary environment for the gift is an honest picture of who and what we are like now. Once we have that picture, we can then choose to change it. We are all dependent on others for that completed picture of ourselves that confrontation provides. First we must identify the wound before healing can take place. Healing and growth are a part of the gift of life itself. They are natural processes. Growth Group can provide the environment for this process to take place.



MLSC.



## WHO IS SHE?

Just who is she, this phantom sage  
Who sets the rules for every age?  
Her curfew's always later than  
The one you've set, and her kids can  
Go places yours are not allowed,  
And mingle with a faster crowd;  
They get permission you'd refuse,  
And get to wear the clothes they choose;  
Her children are not given chores,  
But get more money than do yours;  
What is her name, and where's she from,  
This "Everybody Else's Mom"?

Mary Margaret De Angelis

Your children are not your children.  
They are the sons and daughters of  
Life's longing for itself.  
They come through you, but not from  
You, and though they are with you,  
Yet they belong not to you.  
You may give them your love  
But not your thoughts.  
You may house their bodies,  
But not their souls,  
For their souls dwell in the house  
Of tomorrow, which you cannot visit,  
Not even in your dreams.

--Kahlil Gibran



## FRIEND

You have rejuvenated my life!  
You hugged me and I wanted  
to stay in your arms forever.  
You crept through my defenses  
with your gentle touch.

You angered me when you  
exposed my pain.  
You honored me when you  
stayed to help heal it.

You have given me back  
my poetry!

Because of your gift to me  
I am able to give of myself.  
I am touched, I am becoming  
whole.

I am Your Friend

From a workshop participant

DEAR SANTA CLAUSE

by

A participant in the Student Workshop

*What I want for Chrlistmas  
Elves cannot make  
Nor can you flt it in my stocking  
To Flnd when I wake.  
You cannot buy it at Saks or Bloomingdale's  
Nor at K-Mart, J.C. Penneys, Hallmark, or Zales.  
You cannot wrap it  
Or put it in a box.  
It neither laughs, nor crles,  
Nor even talks.  
You may ask my friends  
Or even me  
And no one can tell you  
Cause Santa, you see. . .  
Nothing you can give me  
Can stop the pain  
Nor the hurt or the anger that  
Drives me Insane.  
Not thls time St. Nick,  
There's nothing you can do  
You can't put It under the tree  
Or buy It brand new.  
This year just glve me prayers  
And love, falth, and hope.  
And let God help mommy and daddy  
Learn just how to cope.  
Maybe once I could see in their cup  
A cool refreshing Ice cold 7-Up.  
That would be a great present,  
I think.  
Just no more booze  
Not another drink.  
I've been good, Santa,  
So think about me.  
I'll leave you some cookles . . .  
If you leave us some tea.*

*Love you,  
F.*

## LISTEN

When I ask you to listen to me  
and you start giving advice  
you have not done what I asked.

When I ask you to listen to me  
and you begin to tell me why I shouldn't feel that way,  
you are trampling on my feelings.

When I ask you to listen to me  
and you feel you have to do something to solve my  
problems,  
you have failed me, strange as that may seem.

Listen. All I asked, was that you listen,  
not talk or do - just hear me.

Advice is cheap: you can get both Dear Abby and  
Billy Graham in the same newspaper.

And I can do for myself; I'm not helpless.

When you do something for me that I can and need to do  
for myself, you contribute to my fear and weakness.

But, when you accept as a simple fact that I do feel what  
I feel, no matter how irrational, then I can quit trying  
to convince you and can get about the business of  
understanding what's behind this irrational feeling.

And when that's clear, the answers are obvious and I  
don't need advice.

Irrational feelings make sense when we understand what's  
behind them.

So, please listen and just hear me. And, if you want to talk,  
wait a minute for your turn; and I'll listen to you.

## LETTING GO

Author Unknown

To "let go" does not mean to stop caring, it means I can't do it for someone else.

To "let go" is not to cut myself off, it's the realization I can't control another.

To "let go" is not to enable, but to allow learning from natural consequences.

To "let go" is to admit powerlessness, which means the outcome is not in my hands.

To "let go" is not to try to change or blame another, it's to make the most of myself.

To "let go" is not to care for, but to care about.

To "let go" is not to judge, but to allow another to be a human being.

To "let go" is not to be in the middle arranging all the outcomes, but to allow others to affect their own destinies.

To "let go" is not to be protective, it's to permit another to face reality.

To "let go" is not to deny, but to accept.

To "let go" is not to nag, scold or argue, but instead to search out my own shortcomings and correct them.

To "let go" is not to adjust everything to my desires but to take each day as it comes, and cherish myself in it.

To "let go" is not to regret the past, but to grow and live for the future.

To "let go" is to fear less and love more.







